						0.11	10 1101 0700 0071
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPI	LETED
		155621	A. BUIL			05/05/2	2011
			B. WINC				
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
				3400 S	TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES	$\overline{}$	ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	 ,	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)	'	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	REGULATORY OR	LISC IDENTIFFING INFORMATION)	+	IAU	DELICIENCE,		DATE
F0000							
			- [
	This visit was	for Investigation of	F00	000	By submittng tthe enclosed matte	rial	
	Complaints IN00089994,				we are nott admittng tthe ttrutth	or	
					accuracy ofl any specific findings of	or	
	IN00089836,	IN00089626, and			allegattons. We reserve tthe right	tto	
	IN00089748.	This visit resulted in			conttestt tthe findings or allegatto		
	a partially ext	ended survey -			partt ofl any proceedings and sub tthese responses pursuantt tto ou		
	immediate jeo	•			regulattory obligattons The flacilit		
	miniculate jee	paray.			requestts tthatt tthe plan ofl corre	-	
					•	ctton	
	Complaint IN	00089994 -		be considered our allegatton of compliance eflective June 4, 2		#o	
	*	No deficiencies					
					tthe complaintt survey conductted	1 011	
	related to the	allegations are cited.			May 5, 2011.		
	Complaint IN	00089836 -					
	*						
	Substantiated.	Federal/state					
	deficiencies re	elated to the					
	allegations are	e cited at F223, F225,					
	_	2 cited at 1 223, 1 223,					
	and F226.						
	Complaint INI	00080626					
	Complaint IN						
	Substantiated.	Federal/state					
	deficiencies re	elated to the					
	anegations are	e cited at F314.					
	Complaint IN	00089748 -					
	_						
	Substantiated. Federal/state						
	deficiencies related to the						
	allegations are	e cited at F223, F225,					
	_	-,,					
	and F226.						
			ı				I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
THIS TETAL	or connection	155621	A. BUII B. WIN			05/05/2	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS'	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	nagozinom on	ESC ISENTING IN COLUMNICAL					5.112
	Unrelated defi	ciencies are cited.					
	Survey date: 5	5/2/11					
	Extended survey dates: 5/3, 5/4,						
	and 5/5/11						
	Facility number: 000442 Provider number: 155621 AIM number: 100266510						
	Survey team:						
	Jennie Bartelt,	RN, TC (5/2, 5/4,					
	and 5/5/11)						
	Diane Hancoci	k, RN (5/2 and					
	5/3/11)						
	Anne Marie C	rays, RN (5/4 and					
	5/5/11)						
	Census bed typ	pe:					
	SNF: 43						
	SNF/F: 62						
	Total: 105						
	Census payor	type:					
	Medicare: 27						
	Medicaid: 46						
	Other: 32						
	Total: 105						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155621	B. WING		05/05/2011
NAME OF F	PROVIDER OR SUPPLIER		3400 8	ADDRESS, CITY, STATE, ZIP CODE STOCKER DR	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER	EVANS	SVILLE, IN47720	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
F0223 SS=J	The resident has the verbally abuse spouse. The facility must not allegations of 8. (Resident Resident F was verbally abuse spouse. The facility must not allegations of 8. (Resident Resident F was verbally abuse spouse. The facility must not allegations of 8. (Resident Resident F was verbally abuse spouse. The facility must not allegations of 8. (Resident F was verbally abuse spouse. The facility must not allegations of 8. (Resident F was verbally abuse spouse. The facility must not allegations of 8. (Resident F was verbally abuse spouse. The facility must not allegations of 8. (Resident F was verbally abuse spouse. The facility must not allegations of 8. (Resident F was verbally abuse spouse. The facility must not allegations of 8. (Resident F was verbally abuse spouse.)	the right to be free from ysical, and mental abuse, ent, and involuntary ot use verbal, mental, abuse, corporal voluntary seclusion. rvation, interview, iew, the facility ethe resident was sical and verbal abuse dents reviewed related of abuse in a sample	F0223	It is the practice of this faci to assure that its residents free from any type of abuse including both physical and verbal abuse, and that any instances are reported to the appropriate agencies as identified per the regulation. The corrective action taken those residents found to be affected by the deficient practice include: Resident free from any form of abuse, physical and verbal, related is spouse. The system identifies the abatement plan has been followed, allowing the spouse.	are e, d ne for e #F is both to the ed in n

000442

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155621			ULTIPLE CO	NSTRUCTION 00	(X3) DATE SU COMPLE	TED		
		155621	B. WIN			05/05/20	11	
NAME OF I	PROVIDER OR SUPPLIEI	8			ADDRESS, CITY, STATE, ZIP CODE			
				1	FOCKER DR			
PINE HA	WEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION	
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	abuse, and the	visiting spouse			supervised visits. Other residents that have the			
	repeated the v	erbal abuse. The		potential to be affected have				
	reporting proc	ess for the second			been identified by: There ha			
		abuse was not			been no other residents iden			
					related to any type of abusiv			
		the facility failed to			situation. However, potentia residents could be affected a			
		olan and implement			the facility policy has been	4110		
	interventions	to prevent further			re-inserviced to assure a			
	abuse.				thorough understanding of the	ne		
					regulation related to abuse prevention and reporting			
	The deficient practice resulted in Immediate Jeopardy. The				immediately to the Administr	ator		
					and appropriate authorities it			
					abusive situation was to			
	Immediate Jed	opardy was identified			occur. The measures or	_		
	on 5/2/11 and	began on 4/23/11.			systemic changes that hav been put into place to ensu			
	The Interim A	dministrator, Director			that the deficient practice does			
	of Nursing A	ssistant Director of			not recur include: The police			
	_	the Social Worker			related to preventing and			
	1				reporting of abuse in any for has been re-inserviced to as			
		of the Immediate			a thorough understanding of			
		/2/11. The Immediate			regulation including the			
	Jeopardy was	removed on 5/4/11,			prevention of abuse and the			
	but the facility	remained out of			proper reporting of abuse in accordance with the guidelin			
	compliance at	the level of isolated,			for reporting of unusual	-		
	1 *	n with potential for			occurrences in a timely man	ner.		
		nimal harm that is not			All staff has been in-serviced	d		
					related to the policy. The			
		opardy, because the			corrective action taken to monitor performance to as	_{sure}		
	facility contin	ued to inservice staff			compliance through quality			
	on abuse police	cies and procedures.			assurance is: A Performance			
		-			Improvement Tool has been	_		
	Findings inclu	ide.			initiated that will be utilized to review the proper following or			
	i munigs men	iuc.			abuse policy including preve			
					of abuse and the notification			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/05/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	5/2/11 at 4:30 hallway through man in street of seated in an earn Resident F). It chair was on, a holding a book. During intervity a.m., LPN #2 were on night Resident F's hall resident F's ha	gh the open door, a clothes was observed asy chair in (room of The light next to the and the man was a in his hands. ew on 5/2/11 at 6:05 and CNA #3 who shift duty on all, indicated the asband is up all night, the resident's room. If that sometimes the ps in the chair. They cone is with Resident ay. They indicated time, a hired sitter is ent, not to provide the staff to the need ais time, the resident's knocked upon, and			the Administrator and approstate agencies. It is the Administrator's responsibilit assure that the appropriate agencies are notified of any allegations in a timely mann The Administrator, or design will complete this audit mon x3, then quarterly x3. The CASSURANCE Committee will represent the tool at the scheduled me following the completion of tool with recommendations needed. The date the system changes will be completed. June 4, 2011	er. nee, thly Quality eview eeting he as	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE	LETED
THIS TELLY	or conditions	155621	1	LDING		05/05/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS'	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
1110		s respirations were		1710			Ditte
	easy.	o respirations (vere					
	casy.						
	Resident F's cl	inical record was					
	reviewed on 5	/2/11 at 6:25 a.m.					
	The record inc	licated the resident					
	was admitted t	to the facility on					
	4/16/11 follow	ring placement of a					
	gastrostomy feeding tube.						
	A Care Confer	ence Note, dated					
	4/27/11, indica	ated in the section for					
	Social Service	s, "Interview w/					
	[with] [name o	of Resident F's					
	husband] rega	rding incident on					
	4/23/11. See S	Social Service Notes					
	for more detai	ls."					
	Social Service	Progress Notes for					
	4/26/11 indica	ted, "Was notified of					
	an incident that	at occurred over the					
	weekend with	resident & her					
	husband. Staf	f reported husband					
	grabbed her by	the hair and shook					
	her. Staff was	assisting the resident					
	with cleaning	up. The husband					
	thought she wa	as being combative.					
	He stated he h	ad Ativan he could					
	give her. He v	vas told all meds					

Facility ID:

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 05/05/2011		
		155621	B. WIN				05/05/20	11	
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE	E, ZIP CODE			
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			VILLE, IN47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	=	(X5) COMPLETION DATE	
	[medications]	needed to go through		ĺ					
		be ordered by a							
	_	oke to the son [name							
		d prepared statement							
	=	r. '[Name of husband]							
		us to hear both sides							
	of the story.	He feels we have							
	*	l] bad information.							
	He feels the re	eport being made							
	would be false	e as it is currently							
		ould be well-advised							
	to listen to wh	at he has to say							
	before making	the final report.'							
	[Name of son]	would not discuss							
	any history of	aggression or abuse							
	with his father	. He stated he would							
	not discuss it	over the phone. He							
	also stated he	would not likely							
	discuss his par	rents at the meeting,							
	but would be t	there for moral							
	support. Supe	rvised visitation has							
	been put into	place and a visit log							
	has been place	ed in the resident							
	_	e when someone is in							
	the room with	the resident. A mtg							
		been scheduled with							
	[name of husb								
	tomorrow at 2	-							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	 DB3N11	Facility I	D: 000442	If continuation she	eet Pag	e 7 of 84	

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Social Service Progress Notes for	(X5) MPLETION DATE
PINE HAVEN HEALTH AND REHABILITATION CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Social Service Progress Notes for 3400 STOCKER DR EVANSVILLE, IN47720 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COID Social Service Progress Notes for	MPLETION
PINE HAVEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Social Service Progress Notes for EVANSVILLE, IN47720 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COLUMN TAG OF THE CONTROL O	MPLETION
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Social Service Progress Notes for PREFIX PREFIX CEACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COLUMN TAG	MPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Social Service Progress Notes for	
4/27/11 + 2.00 : 1: + 1	
4/27/11 at 2:00 p.m. indicated,	
"Social Services [name of SW #2],	
Administrator [name of Interim	
Administrator], Nursing [name of	
Compliance Nurse, LPN #3] met	
with [name of Resident F's	
husband] and son, [name of son].	
[Name of Resident F's husband]	
wanted to express his side of the	
story regarding the incident that	
occurred on 4/23/11. He admits his	
wife was upset & angry with the	
nurses for needing to change her.	
He admits he did grab her hair, but	
did not pull it and did not shake her	
head. He stated he did it because	
after 63 years of marriage he knows	
she does not like her hair being	
pulled. He states he would never	
give his wife his medication and	
understands all medicine must go	
through the physician and the	
facility. [Name of Resident F's	
husband] denies any wrong doing	
and states the staff is just out to get	
him. [Name of Interim	
Administrator], myself, and [Name	
of LPN #3] then spoke to [name of	

000442

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S		
		155621	B. WIN			05/05/2	011
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE TOCKER DR	•	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG		t the incident. She		IAG			DAIL
	_	ritten statement as to					
	what happened. She states [name						
	of Resident F's	s husband] grabbed					
	her [Resident	F] by the hair and					
	shook her head	d. She states she did					
	ask him to stop	and told him that					
	she had the sit	uation under control.					
	[Name of CNA #6] states she then						
	reported it to the nurse on duty. A						
	report was sen	t to the state dept					
	[department] o	of health on 4/27/11."					
	D::	5/0/11 -4 (-15					
		ew on 5/2/11 at 6:15					
	· · · · · · · · · · · · · · · · · · ·	indicated Resident F's					
		resident's room with					
	the resident an						
		about 2:15 a.m. that					
		the son indicated to					
		s going home to get					
		PN #2 indicated the					
	the resident's c	ry concerned about					
		dent F's husband					
		with the resident's					
	l	ff provides care, but					
		alls for assistance as					
	needed.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE SURV COMPLETED		
		155621	B. WIN			05/05/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
PINF HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,0	(X	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ew on 5/2/11 at 6:30					
	a.m., in regard						
		ote, dated 4/27/11,					
		ted he did not know					
	i -	t an incident with					
	Resident F's h	usband.					
		5/0/11 5.05					
	During interview on 5/2/11 at 7:05						
	a.m., CNA #3 was observed						
	1	on Resident F's hall.					
		ew at this time, CNA					
		ne wasn't aware of					
		usband ever being					
		ent F. CNA #3 also					
		isually worked					
		e facility's second					
	_	providing the care on					
	Resident F's ha	all at this time.					
		0. 44. 4					
		facility's binder					
	containing file						
	reported to the						
	_	Health included, but					
		d to, a report titled,					
	· ·	ent Reporting Form,"					
	for "Incident I						
	Incident Time:	6:15 a.m."					
		e report was copy of					
	a handwritten	statement, dated					

000442

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/05/20	ETED	
NAME OF I	PROVIDER OR SUPPLIER	!! }			ADDRESS, CITY, STATE, ZIP CODE	l	
		REHABILITATION CENTER			ΓOCKER DR VILLE, IN47720		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	VILLE, 11147720		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	· -	DATE
		statement indicated,					
	"I [name of C	NA #6] entered the					
	room of [name	e of Resident F] to					
	change her and get her dressed.						
	She was wet,	she was digging at her					
		er nails keeping					
		soar [sic]. I was					
	holding her ha	ands so she would not					
	dig at herself. [Resident F's]						
	husband kept saying to [name of						
	Resident F] le	t go of her. I					
	explained to h	im that I was the one					
	holding her ha	ands so that she didn't					
	scratch hersel	f. [Name of Resident					
	F's husband] g	got up from his seat					
	and grabbed [1	name of Resident F]					
	by the hair of	the head and began					
	shaking her he	ead by the hair of her					
	head yelling lo	et go of her. He made					
	the statement	that he had Adavan					
	[sic] [Ativan -	antianxiety					
	medication] in	his pocket & that he					
	would give he	r some. I explained					
	that no he cou	ld not do that."					
	Also attached	to the Facility					
	Incident Repo	rting Form was copy					
	of an e-mail, of	lated 4/25/11 at 12:43					
	p.m., sent fror	n [name of LPN #4]					

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/05/2011	
			B. WINC		DDRESS, CITY, STAT	E, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			OCKER DR			
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANSV	/ILLE, IN47720			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLA (EACH CORRECTIVE	AN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			COMPLETION DATE
	to LPN #3. T	he e-mail indicated,						
	"On April 23,	2011, my two aides						
	were discussir	ng the care of a						
	resident with 1	me. One stated that						
	the husband h	ad tried to pull her						
	hair while the	y were taking her to						
	the bathroom.							
	commit [sic] t	hat the husband was						
	being mean to	the wife. The second						
	aide reported	that he was not being						
	mean to her he	e was trying to keep						
	her from being	g combative while						
	they were taki	ng her to the						
	bathroom. I w	vas the nurse on the						
	unit at the tim	e and did not see or						
	hear this take	place. I was in the						
	residence [sic]	room frequently that						
	shift and did n	ot observe the						
	husband being	g mean to his wife.						
	He did report	that she needed						
	something to 1	keep her calm at						
	which point I	called the on call						
	physician and	got orders for PRN						
	[as needed] A	tivan 1 mg along with						
	a urinalysis. S	She was placed on						
	acute charting	at that time for the						
	Ativan order."	,						
	The Facility I	ncident Reporting						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	DB3N11	Facility II	D: 000442	If continuation shee	t Pa	ge 12 of 84

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621		LDING	NSTRUCTION 00	(X3) DATE COMPI 05/05/2	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	•	3400 ST	NDDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
TAG	In the section of Incident: "I was providing resident follow episode with he roomAccorduring interview around 2:00 pt that he did gradenied pulling head. Husban his wife any madmit to carry medication with visits." In the section Measures Take monitored throacute charting following the order for profer for profer for profers of Monday personal sitter	for Brief Description [Name of CNA #6] patient care for ving an incontinent nusband in ding to husband ew on April 27th .m., husband states b his wife's hair but g or shaking of wife's d also denied offering nedication, but does ing his own th him during his for Preventive en: "Resident was oughout weekend and was initiated placement of a new Ativan. d supervised visits.		TAG	DEFICIENCY)	ALE	DATE
	with care. A v	visitor log has been					

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED 7/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP (TOCKER DR SVILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	filled out by verification for the faregarding time incidents of all next scheduled. On 5/2/11 at 8 were observed. One of the medicated the faregarding intervirus for the faregarding for the	ely reporting of leged abuse before				
		eted on 5/2/11 at 8:35				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO LDING	INSTRUCTION 00	l' '	E SURVEY PLETED	
		155621	B. WIN			05/05/	/2011
	PROVIDER OR SUPPLIER			3400 ST	ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		<u> </u>	VILLE, IN47720		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE
	a.m. SW #2 h	ad come to the					
	Conference Ro	oom where clinical					
	records were b	eing reviewed to					
	locate the clini	ical record for					
	Resident F. S'	W #2 indicated she					
	wanted to put	her note from Friday					
	[4/29/11] abo	ut an incident with					
	Resident F's h	usband into the					
	clinical record	. SW #2 indicated					
	Resident F's h	usband had not been					
	physically abu	sive but had called					
	the resident na	mes. SW #2					
	indicated [nam	ne of Resident F's					
	husband] won'	t talk on the phone,					
	because he is l	nard of hearing. She					
	indicated he w	ras in the military and					
	that you "can t	tell he wants things					
	done a certain	way and expects it."					
	SW #2 indicat	ed Resident F had					
	excoriation to	her periarea, which is					
	painful for her	. SW #2 indicated					
	she had contac	eted the local					
	Ombudsman t	o brainstorm about					
	possible ideas	to manage the					
	resident, so the	e resident's husband					
	will be manage	ed. SW #2 indicated					
	the son doesn't	t want to intervene as					
	best she can te	ll. SW #2 indicated					
	the family has	kept the resident at					
	!						-

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE SU COMPLE	
		155621	A. BUI B. WIN			05/05/20	
NAME OF I	PROVIDER OR SUPPLIER		D. WII	_	ADDRESS, CITY, STATE, ZIP CODE		
				1	TOCKER DR		
		REHABILITATION CENTER			VILLE, IN47720		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JΈ	DATE
	home until she	had the G-tube					
	placed before	admission. SW #2					
	indicated as fa	r as she could tell,					
	the resident ha	d not had much					
	change in care	needs except for the					
	G-tube care. S	SW #2 indicated she					
	didn't want to	tell the resident's					
	husband not to	come in to visit.					
	She indicated	the problems between					
	the resident an	d her husband had					
	occurred durin	g care in the					
	morning. She	indicated Resident					
	F's husband ha	is usually left the					
	building before	e she arrives. SW #2					
	indicated she p	planned to give					
	Resident F's h	usband and son					
	information ab	out resident abuse.					
	In her hand SV	W #2 had a list of					
	ideas on a red	piece of paper, which					
	she indicated v	were the ideas she					
	and the Ombu	dsman discussed, and					
	an envelope ac	ddressed with the					
	names of Resid	dent F's husband and					
	son.						
	The Social Ser	rvice Progress Notes,					
	dated 4/29/11	at 8:00 a.m.,					
	•	cial Services was					
	notified at 7:4:	5 a.m. that another					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	MULTIPLE CO	NSTRUCTION 00		(X3) DATE : COMPL	
THEFTERN	or condition	155621		ILDING			05/05/2	
			B. WIN		DDRESS, CITY, STAT	E, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OCKER DR	,		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLA (EACH CORRECTIVE	AN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED		ΓE	COMPLETION DATE
		ccurred with [name						
	of Resident F's	s husband]. When I						
	went to the res	sident room to						
	address the inc	cident [name of						
	Resident F's h	usband] had already						
	been picked up	by his son, [name of						
	Resident F's so	on]. The sitter, [name						
	of sitter] was s	still in the room. I						
	questioned her	about the						
	happenings in	the room. She states						
	the CNAs wer	e providing pericare						
	because she ha	ad an incontinent						
	episode. [Nan	ne of resident F] was						
	combative bec	ause of the pain and						
	confusion. Sh	e states, '[Name of						
	resident F's hu	sband] said stop						
	acting like a 4	yr [year] old & told						
	her to shut up.	' She states he did						
	not get physica	al with his wife. I						
	then questione	ed CNA [name of						
	CNA #6]. She	e states [Name of						
	Resident F's h	usband] doesn't						
	understand tha	at [name of Resident						
	F] is in a lot of	f pain from how raw						
	she is and is no	ot trying to fight them						
	in spite. She s	tates he said, 'Shut						
	up, [name of R	Resident F], Shut up						
	[name of Resid	dent F] - quit acting						
	like a 4 yr old.	'He also said, 'You						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	L DB3N11	Facility I	D: 000442	If continuation sl	neet Pa	ge 17 of 84

	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MU A. BUIL B. WING		STRUCTION 00		(X3) DATE : COMPL 05/05/2	ETED
NAME OF 1	DROVIDED OF CURBURY		D. WIN		DDRESS, CITY, STAT	E, ZIP CODE		
	PROVIDER OR SUPPLIEI				OCKER DR			
		REHABILITATION CENTER			ILLE, IN47720			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX		AN OF CORRECTION ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCEI	O TO THE APPROPRIATI	E	DATE
	can't talk to so	omeone without a						
	brain.' [Name	of Resident F] then						
	whispered to [name of CNA #6],						
	'Make him sto	p, make him stop!'						
	[Name of CN.	A #6] states as she and						
	other aid [sic]	were leaving the						
	room he went	to the bedside & tried						
	to tell resident	t that the staff was not						
	trying to hurt	her. I then questioned						
	[name of CN.	A #4], the other CNA.						
	She states he	did tell her to shut up						
	and yelled at l	ner. She states this is						
	not the first ti	me. She states he has						
	been verbally	abusive with his wife						
	and with staff	in the past. She is						
	not sure of the	e exact verbiage. I did						
	try to contact	[name of Resident F's						
	son], but was	unable to do so."						
	Notes on 4/29	/11 at 2:00 p.m.,						
	indicated SW	#2 spoke with the						
		ector of Nursing about						
	the resident's	"being so raw and						
		e." Notes on 4/29/11						
	at 2:30 p.m., i	ndicated SW #2						
	1 -	e Ombudsman about						
	1 ^	plan of care. Will						
	1	rights on abuse for						
		sident F's husband and						
	son]."							
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	 DB3N11	Facility ID	000442	If continuation sh	eet Pa	ge 18 of 84

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/05/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u>"</u> R	-		ADDRESS, CITY, STATE, ZIP CODE		
PINF HA	VEN HEALTH AND	REHABILITATION CENTER		1	ΓOCKER DR VILLE, IN47720		
(X4) ID		STATEMENT OF DEFICIENCIES		ID I	·		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ration on 5/2/11 at oung lady in street					
	I	eated in the easy chair					
		s room. During					
		his time, she indicated					
		sident's private sitter					
		in the room today					
		. to 7:00 p.m. She					
	also indicated	she was employed by					
	the facility as	a housekeeper and					
	would not be j	providing resident					
	care. LPN #5	entered the room and					
	indicated she	would be providing					
	the resident's	water flush to the					
	gastrostomy to	ıbe. Observed on a					
	small table be	side the easy chair					
		led in handwriting,					
		Must Sign In" and a					
	notebook with						
		otations. LPN #5					
		thought the visitor list					
	_	ere by social services,					
	and the sitter i						
		inged to the family					
	and contained						
	resident's care	•					
	During intervi	ew on 5/2/11 at 9:50					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/05/2	ETED
	PROVIDER OR SUPPLIER VEN HEALTH AND	REHABILITATION CENTER	р. үүлү	3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR VILLE, IN47720	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	family to resid 4/23/11, CNA pulling and gratop of her own demonstrated a motion. CNA almost every the room, when the combative, her she indicated thim out of her is holding the she won't dig a During observe for Resident F on 5/2/11 at 10 was observed to the buttock and "Oh that hurts, CNAs' hands observed to ha areas and open tailbone. The	#6 indicated that ime she goes into the e resident is husband yells at her. the resident says "Get e." She indicated she resident's hands so					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	onstruction 00	(X3) DATE SURVI COMPLETED	
		155621	B. WIN			05/05/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	MPLETION DATE
		ew with CNA #4 on					
		a.m., she reiterated					
		ecorded in the Social					
	_	ress Notes for 4/29/11					
		NA #4 indicated she					
	had seen the si	gn in paper in the					
	Resident F's ro	oom, but that no one					
	had said to have	ve people coming into					
	the room to sig	gn in on it. CNA #4					
	indicated, "The	at's his [Resident F's					
	husband's] pap	er, I think."					
	Duning intervi	over on 5/2/11 at 2:15					
	_	ew on 5/2/11 at 2:15					
	Compliance N	im Administrator and					
	_	ncident of verbal					
		lent F by Resident F's					
		29/11 had not been					
	reported to the						
	An Immediate	Jeopardy was					
		/2/11. The Immediate					
	Jeopardy bega	n on 4/23/11 when a					
	visiting spouse	e physically and					
	verbally abuse	d his wife. The					
	Interim Admin	istrator, Director of					
	Nursing, Assis	stant Director of					
	Nursing, and t	he Social Worker					
	were notified of	on 5/2/11 at 3:50 p.m.					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	A. BUIL	DING	NSTRUCTION 00	(c	X3) DATE SURVEY COMPLETED 05/05/2011	
		100021	B. WING		DDDEGG CIMIL CO.	E ZID CODE	00/00/2011	
NAME OF I	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STAT	E, ZIP CODE		
PINE HA		REHABILITATION CENTER			/ILLE, IN47720			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLA (EACH CORRECTIVE	AN OF CORRECTION	(X5)	NT.
TAG	``	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED	TO THE APPROPRIATE (IENCY)	COMPLETION DATE	N
	of the Immedi	ate Jeopardy related						
		o prevent physical						
		use and implement						
		d to prevention,						
	l ⁻	protecting, and						
	reporting abus	se. The Immediate						
	Jeopardy was	removed on 5/4/11 at						
	4:00 p.m., who	en through						
	observations,	interviews, and						
	record reviews	s, it was determined						
	the facility had	d implemented the						
	plan of action	to remove the						
	Immediate Jed	opardy, and that the						
	steps taken rei	moved the immediacy						
	of the problem	n. Review of policy						
	and procedure	e, observations of staff						
	and visitor int	eraction with						
	residents, and	staff interview						
	related to inse	rvicing on the						
	facility's polic	y and procedure						
	related to abus	se, indicated staff was						
	knowledgeabl	e of what and to						
	whom to repor	rt. Even though the						
	facility's corre	ective action removed						
	the Immediate	e Jeopardy, the facility						
	remained out	of compliance at a						
	reduced scope	and severity level of						
	isolated, no ac	etual harm with						
		nore than minimal						
FORM CMS-2	L 2567(02-99) Previous Version	ons Obsolete Event ID:	 DB3N11	Facility II	D: 000442	If continuation she	eet Page 22 of 84	

l	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE A. BUILDING B. WING	00 00		E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400	ET ADDRESS, CITY, STATE, ZIP) STOCKER DR NSVILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	harm that is no Jeopardy.	ot Immediate				
	This federal ta Complaints IN IN00089748. 3.1-27(a)(1) 3.1-27(b)	g is related to 100089836 and				

	IT OF DEFICIENCIES OF CORRECTION				
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 8	ADDRESS, CITY, STATE, ZIP CODE STOCKER DR SVILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=J	have been found or mistreating residuate had a finding nurse aide registry mistreatment of residuate of their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including ir and misappropriat reported immediate the facility and to with State law through (including to the Stagency). The facility must halleged violations and must prevent the investigation is the investigation is the reported to the addrepresentative and accordance with State survey and oworking days of the	nvestigations must be ministrator or his designated to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective			
	ensure allegati	rd review and facility failed to ons of abuse were y to the Administrator	F0225	Itt is tthe practtce ofi tthis fiacilitt assure tthatt any fiorm ofi abuse reportted tto tthe Administtratto tto tthe appropriatte agencies as identtfied per tthe regulatton	is

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155621	- 1	LDING	00	05/05/2011
		100021	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2011
NAME OF F	PROVIDER OR SUPPLIER				TOCKER DR	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	· 	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	and State agen	cy, and failed to			The correctve acton taken fior	
	thoroughly inv	restigate and protect			those residents fiound to be afiec by the deficient practce include :	ted
	the resident du	ring investigation for			There have been no flurtther abus	ive
		s reviewed related to			incidentts bettwee#F and her	
		ple of 8. (Resident			spouse.	
		-			Other residents that have the	
	· ·	was physically and			potental to be afiected have beer identfied by :	'
	_	d by the visiting			Pottenttally all residentts could be	
	spouse and ver	rbally abused by the			aflectted and tthe policy has been	1
	spouse on a se	cond occasion.			re-inserviced tto assure a tthoroug	1
					understtanding of tthe regulatton	
	The deficient r	practice resulted in			There have been no allegattons or observattons of incidentts of abu	1
	Immediate Jeo				witth any otther residentts	36
		pardy was identified			The measures or systemic change	s
					that have been put into place to	
		began on 4/23/11.			ensure that the deficient practce	
		dministrator, Director			does not recur include: The policy relatted tto reporting o	fl
	J	ssistant Director of			any ttype ofl abuse has been	"
	Nursing, and the	he Social Worker			re-inserviced tto assure a tthoroug	gh
	were notified of	of the Immediate			understtanding ofl tthe regulatton	
	Jeopardy on 5/	2/11. The Immediate			including the reporting of abuse	
		removed on 5/4/11,			tthe flacilitty Administtrattor and ounusual occurrences in a ttmely	
	1 2	remained out of			manner tto otther appropriatte	
	_	the level of isolated,			agencies as required by tthe	
	-				regulatton. All sttafl has been	
		with potential for			in-serviced relatted tto tthe policy	
		imal harm that is not			The correctve acton taken to	
		pardy, because the			monitor perfiormance to assure	
	facility continu	ued to inservice staff			compliance through quality	
	on abuse polic	ies and procedures.			assurance is:	
	_				A Perflormance Improvementt Too has been inittatted tthatt will be	וע
					uttlized tto review tthe proper	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155621	B. WIN	IG		05/05/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
				1	TOCKER DR	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		DATE
	Findings inclu	de:			flollowing ofl tthe abuse policy including nottflcatton ofl tthe	
					appropriatte sttatte agenciekt is tt	he
	Resident F's cl	inical record was			Administtrattor's responsibilitty tt	0
	reviewed on 5	/2/11 at 6:25 a.m.			assure tthatt tthe appropriatte age	encies
	The record ind	licated the resident			are nottfled ofl any allegattons in a	
		to the facility on			ttmely manner. The Administtratto or designee, will complette tthis a	·
		ring placement of a			montthly 3, tthen quartterly 3. Th	
		0.1			Qualitty Assurance Committee wil	
	gastrostomy fe	eeding tube.			review tthe ttool att tthe schedule	d
					meettng flollowing tthe completto	
	A Care Confer	ence Note, dated			tthe ttool witth recommendattons	as
	4/27/11, indica	ated in the section for			needed. The date the systemic changes wi	
	Social Service	s, "Interview w/			be completed:	
	with] [name o				June 4, 2011	
		rding incident on				
	, ,	•				
		Social Service Notes				
	for more detail	ls."				
	Social Service	Progress Notes for				
	4/26/11 indica	ted, "Was notified of				
		at occurred over the				
	weekend with					
		f reported husband				
		-				
		the hair and shook				
		assisting the resident				
	with cleaning	up. The husband				
	thought she wa	as being combative.				
	He stated he ha	ad Ativan he could				
		vas told all meds				
	~					
		needed to go through				

000442

Second S	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S		
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER OCATIO SUMMARY STRITMANT OF DEPECTACIS (BLACT IDETCINCY MIST BE PERCEDED BY VILL TAG THE facility & be ordered by a physician" Review of facility binder containing files of incidents reported to the Indiana State Department of Health included, but was not limited to, a report titled, "Facility Incident Reporting Form," for "Incident Date: 4/23/11 Incident Time: 6:15 a.m." Attached to the report was copy of a handwritten statement, dated 4/23/11. The statement indicated, "I [name of CNA #6] entered the room of [name of Resident F] to change her and get her dressed. She was wet, she was digging at her bottom with her nails keeping herself raw & soar [sic]. I was holding her hands so she would not dig at herself. [Resident F's] husband kept saying to [name of Resident F] let go of her. I explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F] Shusband] got up from his seat	THE TEAM	or courternor						
PINE HAVEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEPICIENCEIS PREFETS (16ACH DEPICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OLLS IDENTIFYING INFORMATION) the facility & be ordered by a physician" Review of facility binder containing files of incidents reported to the Indiana State Department of Health included, but was not limited to, a report titled, "Facility Incident Reporting Form," for "Incident Date: 4/23/11 Incident Time: 6:15 a.m." Attached to the report was copy of a handwritten statement, dated 4/23/11. The statement indicated, "I [name of CNA #6] entered the room of [name of Resident F] to change her and get her dressed. She was wet, she was digging at her bottom with her nails keeping herself raw & soar [sic]. I was holding her hands so she would not dig at herself. [Resident F's] husband kept saying to [name of Resident F] to explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat	NAME OF F			D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES 1D PROPRIET PROPRIET PROPRIET PROPRIET PROPRIET PROPRIET PROPRIET PROPRET PROPRIET PROPRIET PROPRIET PROPRET PRO	NAME OF F	ROVIDER OR SUPPLIER			1			
TAG TAG TAG TAG TAG TAG TAG TAG	PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS'	VILLE, IN47720		
the facility & be ordered by a physician" Review of facility binder containing files of incidents reported to the Indiana State Department of Health included, but was not limited to, a report titled, "Facility Incident Reporting Form," for "Incident Date: 4/23/11 Incident Time: 6:15 a.m." Attached to the report was copy of a handwritten statement, dated 4/23/11. The statement indicated, "I [name of CNA #6] entered the room of [name of Resident F] to change her and get her dressed. She was wet, she was digging at her bottom with her nails keeping herself raw & soar [sic]. I was holding her hands so she would not dig at herself. [Resident F's] husband kept saying to [name of Resident F] explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat								
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dig at herself. [Resident F's] husband kept saying to [name of Resident F] let go of her. I explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat		herself raw &	soar [sic]. I was					
husband kept saying to [name of Resident F] let go of her. I explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat		holding her ha	nds so she would not					
Resident F] let go of her. I explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat		dig at herself.	[Resident F's]					
explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat		husband kept s	saying to [name of					
holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat		Resident F] let	go of her. I					
scratch herself. [Name of Resident F's husband] got up from his seat		explained to h	im that I was the one					
F's husband] got up from his seat		holding her ha	nds so that she didn't					
		scratch herself	. [Name of Resident					
and grabbed [name of Resident F]		F's husband] g	ot up from his seat					
,		and grabbed [r	name of Resident F]					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621				LDING	nstruction 00	(X3) DATE S COMPLI 05/05/20	ETED
NAME OF I	PROVIDER OR SUPPLIEF	 	P. (12	STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		REHABILITATION CENTER		1	ΓOCKER DR VILLE, IN47720		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	VILLE, 11147720		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'-	DATE
	~	the head and began					
		ead by the hair of her					
	, ,	et go of her. He made					
		that he had Adavan					
	[sic] [Ativan -						
	1 -	his pocket & that he					
	I -	r some. I explained					
	that no he cou	ld not do that."					
		. 4 5 40					
		to the Facility					
	1 *	rting Form was copy					
	· ·	lated 4/25/11 at 12:43					
	l *	n [name of LPN #4]					
		he e-mail indicated,					
	1 -	2011, my two aides					
		ng the care of a					
		me. One stated that					
		ad tried to pull her					
	1	y were taking her to					
	l	Aide made the					
		hat the husband was					
	_	the wife. The second					
	1 -	that he was not being					
		e was trying to keep					
		g combative while					
	they were taki						
		vas the nurse on the					
		e and did not see or					
	hear this take	place. I was in the					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SUR COMPLETE	ED	
		155621	B. WIN			05/05/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION DATE
	residence [sic]	room frequently that					
	shift and did n	ot observe the					
	husband being	mean to his wife.					
	He did report t	that she needed					
	something to k	teep her calm at					
	which point I	called the on call					
	physician and	got orders for PRN					
	[as needed] At	ivan 1 mg along with					
	a urinalysis. S	the was placed on					
	acute charting	at that time for the					
	Ativan order."						
	· ·	ncident Reporting					
	· ·	ection for Preventive					
	Measures Take						
	"Resident was						
		ekend and acute					
		nitiated following the					
	_	new order for prn					
		nmended supervised					
		Monday April 25th, a					
	_	had been hired by					
	· -	bedside to assist					
		risitor log has been					
	_	esident's room to be					
	· ·	isitor or sitter. No					
		its of physical abuse					
		ed. Nurse will be					
	educated on fa	cility policy					

000442

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE O A. BUILDING B. WING	OONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/05/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400	r address, city, state, zip code STOCKER DR SVILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
		ly reporting of leged abuse before I shift."			
	Facility Incide indicated, "E-r Indiana State I employee] 4/2 5:10 by [name Administrator] statements 4 p Interview with #2 was comple a.m. SW #2 h Conference Rorecords were b locate the clinical record Resident F's his clinical r	to include ages total." Social Worker (SW) eted on 5/2/11 at 8:35 ad come to the com where clinical reing reviewed to acal record for W #2 indicated she her note from Friday at an incident with asband into the SW #2 indicated usband had not been sive but had called			
	The Social Ser	vice Progress Notes,			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE COMPI	LETED
		155621	B. WIN			05/05/2	2011
NAME OF I	PROVIDER OR SUPPLIER		·		ADDRESS, CITY, STATE, ZIP CODE FOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS'	VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	dated 4/29/11	at 8:00 a.m.,					
	indicated, "So	cial Services was					
	notified at 7:4:	5 a.m. that another					
	incident had o	ccurred with [name					
	of Resident F's	s husband]. When I					
	went to the res	sident room to					
	address the inc	eident [name of					
	Resident F's h	usband] had already					
	been picked up	by his son, [name of					
	Resident F's so	on]. The sitter, [name					
	of sitter] was s	still in the room. I					
	questioned her	about the					
	happenings in	the room. She states					
	the CNAs wer	e providing pericare					
	because she ha	ad an incontinent					
	episode. [Nan	ne of resident F] was					
	combative bec	ause of the pain and					
	confusion. Sh	e states, '[Name of					
	resident F's hu	sband] said stop					
	acting like a 4	yr [year] old & told					
	her to shut up.	' She states he did					
		al with his wife. I					
	then questione	ed CNA [name of					
	CNA #6]. She	e states [Name of					
	Resident F's h	usband] doesn't					
		at [name of Resident					
	F] is in a lot of	f pain from how raw					
		ot trying to fight them					
	in spite. She s	tates he said, 'Shut					

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				MULTIPLE COI JILDING	00	COMPI	LETED
		155621	B. WI	NG		05/05/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
IAG		Resident F], Shut up		TAG	BEFELENCTY		DATE
	* -	dent F] - quit acting					
	=	'He also said, 'You					
	· ·	meone without a					
		of Resident F] then					
	_	name of CNA #6],					
	_	p, make him stop!'					
	l .	A #6] states as she and					
	other aid [sic]	were leaving the					
	room he went	to the bedside & tried					
	to tell resident	that the staff was not					
	trying to hurt l	ner. I then questioned					
	[name of CNA	A #4], the other CNA.					
	She states he d	lid tell her to shut up					
	and yelled at h	ner. She states this is					
	not the first tir	ne. She states he has					
	been verbally	abusive with his wife					
		in the past. She is					
		exact verbiage. I did					
	*	name of Resident F's					
	_	able to do so." Notes					
		2:00 p.m., indicated					
	_	with the Assistant					
		irsing about the					
	resident's "bei	•					
		e." Notes on 4/29/11					
	_	ndicated SW #2					
	_	Ombudsman about					
	ine ideas on p	olan of care. Will					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621			ULTIPLE CO LDING	NSTRUCTION 00	COM	TE SURVEY MPLETED 5/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP (TOCKER DR VILLE, IN47720		572011
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		rights on abuse for ident F's husband and					
	p.m., the Interior Compliance N indicated the inabuse of Residusband on 4/2 reported to the Administrator facility's proto	ncident of verbal lent F by Resident F's 29/11 had not been m. The Interim					
	Jeopardy begative visiting spoused verbally abused Interim Admiration Nursing, Assist Nursing, and the were notified of the Immediate to the failure to investigate and the visit of the Immediate of the Immediat	Jeopardy was /2/11. The Immediate n on 4/23/11 when a e physically and d his wife. The histrator, Director of stant Director of the Social Worker on 5/2/11 at 3:50 p.m. ate Jeopardy related o report, protect, and allegation of physical ase The Immediate					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
1111212111	or condition,	155621		LDING		05/05/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	FOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER	EVANSVILLE, IN47720		VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1/10		removed on 5/4/11 at		1710	<u> </u>		DAIL
	4:00 p.m., who						
		interviews, and					
	l '	s, it was determined					
		d implemented the					
	plan of action	-					
	Immediate Jed	pardy, and that the					
	steps taken rer	noved the immediacy					
	of the problem	n. Review of policy					
	and procedure	, observations of staff					
	and visitor into	eraction with					
	residents, and	staff interview					
	related to inse	rvicing on the					
	facility's polic	y and procedure					
	related to abus	se, indicated staff was					
	knowledgeabl	e of what and to					
	whom to report	rt. Even though the					
	facility's corre	ctive action removed					
	the Immediate	Jeopardy, the facility					
		of compliance at a					
	1	and severity level of					
	· ·	tual harm with					
	_	nore than minimal					
	harm that is no	ot Immediate					
	Jeopardy.						
	T1: C 1 1.	. 1, 1,					
	This federal ta	-					
	Complaints IN	100089836 and					

PRINTED: 05/31/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621			A. BUILDING B. WING	00	COMPLETED 05/05/2011
	PROVIDER OR SUPPLIER VEN HEALTH AND	REHABILITATION CENTER	STREET A 3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR SVILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=J	written policies and mistreatment, negrand misappropriate Based on reconsistency interview, the ensure its policing related to time allegations of a Administrator and thoroughly protecting the investigation for reviewed relates sample of 8. (Resident F was	facility failed to ey was followed ly reporting of abuse to the and State agency, investigating and resident during or 1 of 4 residents ed to abuse in a	F0226	Itt is tthe practtce ofi tthis fiacilitt assure tthatt tthe Administrattor nottfied immediattely relatted tto allegatton ofi abuse neglectt, or misappropriatton ofi propertty The Administrattor is tthen responsil fior nottfiying tthe appropriatte agencies as required in a ttmely manner per tthe fiacilitty policy at the regulatton The correctve actor taken fior those residents fiound to be affect by the deficient practce include: Resident#F has had no flurtther incidentts relatted tto tthe occurre ofl abuse. Please refler tto systtem changes relatted tto tthe policy are	is pany pany pany pany pany pany pany pany

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DB3N11

Facility ID: 000442

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED
		155621	B. WIN			05/05/2011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE	
DINETIA	\/_N_I_IA_T_I_AND	DELIABILITATION CENTED			TOCKER DR	
		REHABILITATION CENTER		EVAINS	VILLE, IN47720	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG		·		IAG	reporting mechanisms to tihe	DAIL
	1 -	legation was not			Administtrattor and tthe appropria	atte
	1 *	y, and the resident			sttatte agencies	
	was not protect	cted from further			Other residents that have the	
	abuse. A seco	ond allegation of			potental to be afiected have been	,
		reported timely for			identfied by :	
		and protection of the			There have been no incidentts ofl abuse relatted tto any addittonal	
	_	and protection of the			residentts Pottenttally all resident	ts
	resident.				could be aflectted and tthereflore	I
					currentt policy has been reinservio	ced
	The deficient	practice resulted in			tto assure a tthorough understtan	ding
	Immediate Jed	opardy. The			ofl tthe regulatton	
		opardy was identified			The measures or systemic change	es
		began on 4/23/11.			that have been put into place to ensure that the deficient practce	
		-			does not recur include:	
		dministrator, Director			The policy relatted tto tthe preven	itton
	of Nursing, A	ssistant Director of			and tthe reporttng ofl any florm of	fi
	Nursing, and t	the Social Worker			abuse has been re-inserviced tto	
	were notified	of the Immediate			assure a tthorough understtanding	g ofl
	 Jeonardy on 5	/2/11. The Immediate			tthe regulatton including tthe immediatte nottflcatton of tthe	
		removed on 5/4/11,			Administtrattor and tthe reporttng	z ofl
					unusual occurrences in a ttmely	, •
	1	remained out of			manner. All sttafl has been	
	compliance at	the level of isolated,			in-serviced relatted tto tthe policy	
	no actual harn	n with potential for			The correctve acton taken to	
	more than mir	nimal harm that is not			monitor perfiormance to assure compliance through quality	
	Immediate Jed	opardy, because the			assurance is:	
		ued to inservice staff			A Perflormance Improvementt Too	ol
					has been inittatted tthatt will be	
	on abuse poin	cies and procedures.			uttlized tto review reporttable eve	I
					tto assure tthatt tthey are reportte	
	Findings inclu	ıde:			ttmely in accordance witth tthe fla policy and tthe regulatton Itt is tth	· •
					Administtrattor's responsibilitty to	
	The facility's	policy entitled "Abuse			assure tthatt tthe appropriatte age	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155621		LDING	00	05/05/2011
		100021	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2011
NAME OF F	PROVIDER OR SUPPLIER			1	TOCKER DR	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS'	VILLE, IN47720	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
-		as requested and was		-	are nottfled ofl any allegattons in a	
	provided on 5/	/2/11 at 11:00 a.m. on			ttmely manner. The Administtratto	
	the Conference				or designee, will complette tthis a montthly &, tthen quartterly & Th	
	Review of the	policy indicated,			Qualitty Assurance Committee wil	
	"Policy:	1 5			review tthe ttool att tthe schedule	
		spicions/reports of			meettng flollowing tthe completto tthe ttool witth recommendattons	
	abuse will be i				needed.	
		ensure the safety			The date the systemic changes wi	iii
		g of the resident."			<i>be completed:</i> June 4, 2011	
	l –	e sections included,			,	
		mited to, "Any team				
		knowledge of an				
		incident will report it				
	_	the unit/charge				
	nurse, supervis	•				
		, DON [Director of				
	Nursing], or	, [
	Administrator.	Nursing				
	administration					
		will submit a written				
		opropriate state and				
		" The Prevention				
		ed, but was not				
		eported instances of				
		ve situations will be				
	l -	nmediately and				
	reported to the	· ·				
		l agenciesReview				
		nd assess some of the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE :		
		155621	A. BUII B. WIN			05/05/2	011
NAME OF I	PROVIDER OR SUPPLIER		_	1	ADDRESS, CITY, STATE, ZIP CODE	1	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	COMPLETION
TAG	following opti		-	TAG	DEFICIENCY)		DATE
	monitoring of						
	_	ep the resident from					
	_	Is it necessary to					
	consider conta						
		vices if a family					
	member or gua	ardian is involved?					
	Witness state	ement should be					
	documented as	s soon after the					
	_	ssible. Nursing					
	administration	<i>'</i>					
		will be notified					
	l	f any alleged incident					
	_	ative process can					
		cautionary measure					
	further probler	et the resident from					
	Turtilei problei	115.					
	Resident F's cl	inical record was					
		/2/11 at 6:25 a.m.					
		licated the resident					
	was admitted t	to the facility on					
		ring placement of a					
	gastrostomy fe	eeding tube.					
		ence Note, dated					
		ated in the section for					
		s, "Interview w/					
	[with] [name o	of Resident F's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621		LDING	NSTRUCTION 00	(X3) DATE COMPI 05/05/2	LETED	
NAME OF I	PROVIDER OR SUPPLIE	R	1	ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER	1	TOCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	1 -	rding incident on Social Service Notes ils."				
	4/26/11 indication an incident the weekend with husband. State grabbed her between her. Staff was with cleaning thought she were He stated her is give her. He [medications] the facility & physician"	e Progress Notes for at ed, "Was notified of at occurred over the resident & her off reported husband by the hair and shook as assisting the resident up. The husband has being combative. The husband has being combative and Ativan he could have told all meds needed to go through the ordered by a				
	reported to the Department o was not limited "Facility Incident Incident Timed Attached to the Department of the Departm	es of incidents e Indiana State f Health included, but ed to, a report titled, dent Reporting Form," Date: 4/23/11				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	ì	E SURVEY PLETED 7/2011	
PINE HA	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP (TOCKER DR SVILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	4/23/11. The s "I [name of Change her and change her and she was wet, shottom with he herself raw & holding her hadig at herself. husband kept shoulding her has cratch herself. F's husband] gand grabbed [rhouse head yelling her	statement indicated, NA #6] entered the e of Resident F] to d get her dressed. She was digging at her er nails keeping soar [sic]. I was nds so she would not [Resident F's] saying to [name of t go of her. I im that I was the one nds so that she didn't E. [Name of Resident tot up from his seat hame of Resident F] the head and began ead by the hair of her et go of her. He made that he had Adavan antianxiety his pocket & that he er some. I explained lid not do that."	TAG			DATE
	p.m., sent fron	n [name of LPN #4]				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		100021	B. WIN			05/05/2	UII
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	to LPN #3. Th	ne e-mail indicated,					
	"On April 23,	2011, my two aides					
	were discussin	g the care of a					
	resident with n	ne. One stated that					
	the husband ha	nd tried to pull her					
	hair while they	were taking her to					
	the bathroom.	Aide made the					
	commit [sic] the	hat the husband was					
	_	the wife. The second					
	•	hat he was not being					
	mean to her he	was trying to keep					
	_	g combative while					
	they were taking	· ·					
		as the nurse on the					
		e and did not see or					
	_	place. I was in the					
		room frequently that					
	shift and did n						
	_	mean to his wife.					
	_	hat she needed					
	_	teep her calm at					
	•	called the on call					
		got orders for PRN					
		ivan 1 mg along with					
		the was placed on					
		at that time for the					
	Ativan order."						
	The Facility In	ncident Reporting					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		A. BUI	LDING	NSTRUCTION 00	C	OATE SURVEY OMPLETED O5/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP COD OCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Form, in the see Measures Take "Resident was throughout we charting was in placement of a Ativan. Recorvisits. As of Measures Take of Measures are throughout we charting was in placement of a Ativan. Recorvisits. As of Measures are the family to sit at with care. A we placed in the refilled out by wifurther incident have been noted educated on faregarding time incidents of all next scheduled. A handwritten Facility Incide indicated, "E-refindiana State Indiana Indi	ection for Preventive en, indicated, monitored ekend and acute nitiated following the new order for prn mended supervised Monday April 25th, a had been hired by bedside to assist risitor log has been esident's room to be distor or sitter. No ats of physical abuse ed. Nurse will be cility policy ely reporting of leged abuse before I shift." notation on the nt Reporting Form" mailed to [name if Department of Health 7/11; 4/27/11 Faxed		I	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	
	Administrator] statements 4 pa	to include					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 05/05	E SURVEY PLETED /2011			
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN47720					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
IAG	Interview with #2 was comple a.m. SW #2 h Conference Rorecords were belocate the clinical record Resident F's highly sically about the resident resident resident resident natural The Social Sendated 4/29/11 indicated, "Social Sendated 4/29/11 indicated 4/29/11 indicated, "Social Sendated 4/29/11 indicated 4/29/11 indicated 4/29/11 indicated 5/29/11 ind	a Social Worker (SW) eted on 5/2/11 at 8:35 ad come to the com where clinical being reviewed to ical record for W #2 indicated she her note from Friday ut an incident with usband into the . SW #2 indicated usband had not been sive but had called umes. Evice Progress Notes, at 8:00 a.m., cial Services was 5 a.m. that another ccurred with [name as husband]. When I sident room to cident [name of usband] had already o by his son, [name of on]. The sitter, [name still in the room. I reabout the	IAG	DEFICIENCY		DATE		
	nappenings in	the room. She states						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	155621		UILDING	00		COMPL 05/05/2	
		130021	B. W		DDRESS, CITY, STA	ATE ZID CODE	00/00/2	· · ·
NAME OF I	PROVIDER OR SUPPLIER				OCKER DR	ALE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		I	VILLE, IN47720			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCI	ED TO THE APPROPRIATI FICIENCY)	E	COMPLETION DATE
	the CNAs wer	e providing pericare						
	because she ha	ad an incontinent						
	episode. [Nan	ne of resident F] was						
	combative bec	ause of the pain and						
	confusion. Sh	e states, '[Name of						
	resident F's hu	sband] said stop						
	acting like a 4	yr [year] old & told						
	her to shut up.	' She states he did						
	not get physica	al with his wife. I						
	then questione	ed CNA [name of						
	CNA #6]. She	e states [Name of						
	Resident F's hu	usband] doesn't						
	understand tha	at [name of Resident						
	F] is in a lot of	f pain from how raw						
	she is and is no	ot trying to fight them						
	in spite. She s	tates he said, 'Shut						
	up, [name of R	Resident F], Shut up						
	[name of Resid	dent F] - quit acting						
	like a 4 yr old.	' He also said, 'You						
	can't talk to so	meone without a						
	brain.' [Name	of Resident F] then						
	whispered to [name of CNA #6],						
	'Make him sto	p, make him stop!'						
	[Name of CNA	A #6] states as she and						
	other aid [sic]	were leaving the						
	room he went	to the bedside & tried						
	to tell resident	that the staff was not						
	trying to hurt h	ner. I then questioned						
	[name of CNA	A #4], the other CNA.						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	DB3N ²	11 Facility I	D: 000442	If continuation sh	eet Pa	ge 44 of 84

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MUL A. BUILD B. WING		00	(X3) DATE S COMPL 05/05/2	ETED
NAME OF PROVIDER OR SUPPLIE	REHABILITATION CENTER		3400 ST	DDRESS, CITY, STATE, ZIP CODE OCKER DR //ILLE, IN47720	1	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
She states he and yelled at not the first theen verbally and with staff not sure of the try to contact son], but as won 4/29/11 at SW #2 spoked Director of Noresident's "become uncomfortable at 2:30 p.m., spoke with the "ideas on leave resident [names of Reson]." During intervent p.m., the Intervent compliance indicated the abuse of Reson husband on 4 reported to the Administrator.	did tell her to shut up her. She states this is me. She states he has a busive with his wife f in the past. She is e exact verbiage. I did [name of Resident F's nable to do so." Notes 2:00 p.m., indicated with the Assistant fursing about the ing so raw and e." Notes on 4/29/11 indicated SW #2 e Ombudsman about plan of care. Will t rights on abuse for sident F's husband and riew on 5/2/11 at 2:15 rim Administrator and Nurse, LPN #3, incident of verbal dent F by Resident F's /29/11 had not been em. The Interim r indicated the ocol for reporting					

Facility ID:

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	COMPL	ETED	
		155621	B. WIN			05/05/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		abuse had not been		IAU			DATE
	followed.	abase had not been					
	Tollowed.						
	An Immediate	Jeopardy was					
		/2/11. The Immediate					
	Jeopardy bega	n on 4/23/11 when a					
	visiting spouse	e physically and					
	verbally abuse	d his wife. The					
	Interim Admin	istrator, Director of					
	Nursing, Assis	stant Director of					
	Nursing, and t	he Social Worker					
	were notified of	on 5/2/11 at 3:50					
	p.m., of the Im	mediate Jeopardy					
	related to the f	ailure to follow					
	policies related	d to reporting,					
	protecting resi	dents, and					
		n allegation of					
		erbal abuse. The					
		pardy was removed					
	on 5/4/11 at 4:	• '					
		vations, interviews,					
	and record rev						
	determined the	•					
	_	he plan of action to					
		mediate Jeopardy,					
		eps taken removed					
	·	of the problem.					
	_	icy and procedure,					
	observations o	f staff and visitor					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		A. BUILDI B. WING		00	COMPL 05/05/2	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		3400 ST	DDRESS, CITY, STATE, ZIP CODE OCKER DR /ILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	interview relathe facility's perelated to abuse knowledgeable whom to report facility's correct the Immediate remained out or reduced scope isolated, no acceptantial for many that is not Jeopardy.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) M A. BUII B. WIN	LDING G	ONSTRUCTION 00	(X3) DATE COMPI 05/05/2	LETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
F0241 SS=D	a manner and in a maintains or enha	promote care for residents in an environment that nces each resident's dignity recognition of his or her					
	Based on obse	ervation and	F0	241	Itt is tthe practice ofi tthis fiacilit	ty tto	06/04/2011
	interview, the	facility failed to			assure tthatt tthe all residentts re		
		as provided to 2 of 8			care and services in a manner an environmentt tthatt mainttains of	-	
		ents, in a manner to			enhances each residentt's dignit		
	•				The correctve acton taken fior	•	
		hance their dignity,			those residents fiound to be afie	cted	
		ere observed to barge			by the deficient practce include :		
	into bathroom	s and/or resident			Residentts#H and #I are botth		
	rooms without	knocking and			receiving care and services in a manner tthatt mainttains ttheir d	ignitty	
	waiting to be a	asked in, and care			Other residents that have the	.8/	
		scussed from hallway			potental to be afiected have bee	n	
		's room. (Residents			identfied by :		
		s room. (Residents			Pottenttally all residentts could b	e	
	H and I)				aflectted Thereflore please see below flor systtemic changes rela	tted	
					tto enhancing residentts' dignitty		
	Findings inclu	de:			The measures or systemic change		
					that have been put into place to		
	1. On 5/2/11 a	at 11:25 a.m., CNA #8			ensure that the deficient practce		
		to open the common			does not recur include: All sttafl has been inserviced rela	ttad	
		-			tto tthe provision ofl enhancing	iteu	
		r, without knocking			residentts' dignitty The in-service	is	
	_	herself, and enter the			inclusive ofl tthe need tto knock of		
	bathroom. She	e had verbalized in			residentts' doors prior tto entteri	ng	
	the hallway, pa	rior to entering, that			and assuring tthatt any conversat		
	she was lookir	ng for her glasses. At			which are relatted tto residentts a	are	
	11:31 a.m., Re				conductted in a privatte manner conducive tto residentts'		
	observed com				confidenttalitty and dignitty		
		_			The correctve acton taken to		
	bathroom in h	er wheelchair. She			monitor perfiormance to assure		
					compliance through quality		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI	PLE CON	ISTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155621	A. BUILDIN	IG	00	05/05/2	
		100021	B. WING	PDEET AT	DDDEGG CITY GTATE 7ID CODE	00/00/2	011
NAME OF F	PROVIDER OR SUPPLIER				ODRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			ILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		<u> </u>	·		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	indicated, "An	other thing, there's			assurance is:		
	no privacy in t	the bathroom! They			A Perflormance Improvementt Too	ol .	
	never knock, i	ust come in and out			has been inittatted tthatt will be uttlized tto observe flor tthe provis	sion	
	while I'm in th				ofl dignittydonfldenttalitty The	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	willie I ili ili til	oro.			Directtor ofl Nursingor designee, w	/ill	
					complette tthis auditt weekl		
					montthly 3, tthen quartterly 3. Ar issue identtfled will be immediatte	•	
					correctted The Qualitty Assurance	:i y	
					Committee will review the ttool a	tt	
					tthe scheduled meettng flollowing	tthe	
					completton ofl tthe ttool witth		
					recommendattons as needed. The date the systemic changes wi	,,	
					be completed:	"	
					June 4, 2011		
	2. During inte	erview on 5/2/11 at					
	1:15 p.m., Res	ident I indicated her					
	* 1	ing. As the room was					
	_	8 was observed at the					
	· ·						
		rt in the hallway					
		ent I's room. The					
		out the resident's					
	legs was passe	ed along to LPN #8.					
	LPN #8 called	loudly from the					
	hallway into R	Lesident #8's room,					
	_	sident #8], you want					
	some Tylenol?						
	3.1-31(t)						
	J.1 - J1(t)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 05/05/2	LETED	
PINE HA		REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR SVILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
F0309 SS=D	must provide the rest to attain or maintal physical, mental, as in accordance with assessment and physical on observeriew, and infailed to ensur was thoroughly planned and insimplemented the of 3 residents of 3 resid	rvation, record terview, the facility e the resident's pain y assessed, care terventions o manage pain for 2 reviewed related to le of 8. (Residents E de: ervation on 5/2/11 at NA #4 and CNA #6	F0309	Itt is tthe practice ofi tthis fix assure tthatt tthe all residenthe necessary care and servattain or maintain tthe high practicable physical, mentialy psychosocial well-being, in accordance with tthe comprehensive assessmenthe those residents flound to be by the deficient practice inclusion accordance with the comprehensive assessments a updatted pain assessments a interventions in place tto addiscomflortt Other residents that have the potental to be affected have identified by: All residentts have been reviassure that all residentts the experience pain are having the needs addressed appropriate. The measures or systemic chathat have been put into place ensure that the deficient pradoes not recur include: Nurses have been in-serviced tto assuring tthatt residentts experience pain are ttreatted.	tts receive ices tto estt estt and or afiected ide: dand have dress any e been ewed tto estt heir ely anges e to ctce relatted who	06/04/2011

NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER X40 ID SUMMARY STATEMENT OF DEFICIENCIES EVANSVILLE, IN47720		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPI	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL RAGE ACH CORRECTION OF THE APPROPRIATE DEFICIENCY) and bleeding on Friday (4/29/11), and she told the nurse. Small bright red areas were observed near the anal area, and an open pinkish-yellow open area was observed on the coccyx. The resident stated, "I'm going down here - it hurts" and reached toward the perianal area. CNA #4 and #6 indicated the resident always complained of pain when she was wet and when incontinence care was provided, and they indicated the residents was provided, and they indicated the resident always appropriate interventions in place STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER OR EVANSVILLE, IN47720 (X5) PREFIX CACH CORRECTION (CAS) PR	ANDILAN	or connection		1				
Addo Stocker Dr. Summary statement of deficiencies Cach deficiency must be perceibed by full radio definition of the perianal area. CNA #4 and #6 indicated the resident always complained of pain when she was wet and when incontinence care was provided, and they indicated the resident always and the provision of dap propriate interventtons in place Cach deficiency must be perceibed by full provision perceibed perceibed by full providers plan of correction (Racii correction should be corrected on the correction (Racii correction should be corrected on the prior should be corrected on the corrected of physical pain but of also treating pain prior tto procedures if possible, if a resident is known tto experience pain during the provision of care the compliance to assure compliance to assure compliance through quality assurance is: A Perflormance Improvement Tool has been intitated that will be uttlized tto observe flor the provision of appropriate pain management the tool will randomly reviews residents to assure that all residents with identified pain have appropriate interventions in place				B. WIN		ADDRESS CITY STATE ZIPCODE		
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wet and when incontinence care was provided, and they indicated the residentts the assure that all residentts with identified pain have appropriatte interventions in place			3			· ·		
was provided, and they indicated with identified pain have appropriate interventions in place		complained of	f pain when she was			The ttool will randomly review5		
was provided, and they indicated appropriate interventions in place		wet and when	incontinence care				dentts	
11 Ω 1 1. 11		was provided,	and they indicated			·		
		they often had	I the resident hold the					
hands of one CNA so the other will complette this auditt weekly.		*						
could provide care as the resident monthly 38, then quartterly 38. Any						montthly %, tthen quartterly %. A	ny	
issue identitied will be immediattely							•	
			~			•		
the scheduled meeting following the			-					
after the observation, the nurse, completton of the tool witth								
LPN #5 was asked to assess the recommendations as needed.		LPN #5 was a	sked to assess the					
open area to the coccyx as soon as		open area to the	he coccyx as soon as			-	ill	
possible.		possible.				•		
						Julie 1, 2011		
During interview on 5/2/11 at 12:40		During intervi	iew on 5/2/11 at 12:40					
p.m., LPN #5 indicated she had								
assessed the resident's wound as the		_						
therapists were assisting the			•					
resident back to bed. She indicated								
the wound was a Stage 2 pressure		the wound wa	s a Stage 2 pressure					

	OF CORRECTION	IDENTIFICATION NUMBER:		TLDING	00	COMPI	LETED
		155621	B. WI			05/05/2	<u></u>
NAME OF I	PROVIDER OR SUPPLIEF	2		1	DDRESS, CITY, STATE, ZIP CODE		
 PINF HA	VEN HEAI TH AND	REHABILITATION CENTER			FOCKER DR VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID I	·		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ulcer right on						
	Documentatio	n of the wound					
	description wa	as requested at this					
	time, and LPN	#5 provided a form					
	entitled, "Skin	Ulcer					
	Documentatio	n," dated 5/2/11,					
	which indicate	ed Resident F had a					
	Stage 2 pressu	re ulcer measuring					
	0.8 X 0.9 cm v	with less than 0.1 cm					
	depth. The do	cumentation					
	indicated the r	nurse was unable to					
	assess the resi	dent's pain.					
	The clinical re	ecord for Resident F					
	was reviewed	on 5/2/11 at 6:25 a.m.					
	The Minimum	Data Set assessment,					
	signed as com	pleted 4/29/11 by the					
	RN Coordinat	or, indicated the					
	following in the	ne Care Area					
	Assessment si	gned by SW#2, the					
	Social Service	es Director: "She					
	has severe der	nentia and currently					
	has a feeding	tube. She is alert at					
		oriented. She is very					
	confused and	anxious. She has					
	numerous epis	sodes of incontinence.					
	She has becon	ne very raw and					
		vaginal and anal					
	<u> </u>						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621		(X2) MULT A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPL 05/05/2	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3	3400 ST	DDRESS, CITY, STATE, ZIP CODE OCKER DR /ILLE, IN47720	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
IAU	area causing hepisodes and a She is at times at this time, but is confused	er pain during these Iso during pericare. combative with staff at it it is painful and she She is able to express In on the undated Bent" form, located in Ithe clinical record In assessments, In a check mark, "No Iter documentation was Iter form. Iter Charting notes for Iter and		AU			DATE
		ncont [incontinent]					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CC A. BUILDING B. WING	00	ì	e survey pleted /2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A 3400 S	ADDRESS, CITY, STATE, ZIF TOCKER DR VILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
TAG	care is given [a loose BMs [bots she gets her re Preparation H medication] appropriate [symbol for w Cream." A physician's a Tylenol 325 m was changed of "Administer T [every] 6 [sympeg [gastrostor [diagnosis]: p failed to indicate orders related including as not medications, the Social Service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistant Dire about [name or she was propertied to the service dated 4/29/11 indicated, "Spe [Assistan	symbol for after] owel movements] et ctum washed. [hemorrhoid oplied per order along ith] Magic Butt admission order for ag, two every 6 hours on 4/20/11 to, ylenol 1000 mg. q abol for hours] per my] tube. Dx ain." Documentation ate further physician's to pain management, eeded pain hrough 5/4/11. Progress Notes, at 2:00 p.m.,	TAG	DEFICIENCY		DATE
	anything else					

PRINTED: 05/31/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MUL' A. BUILD! B. WING		NSTRUCTION 00	(X3) DATE : COMPL 05/05/2	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	:	3400 ST	DDRESS, CITY, STATE, ZIP CODE COCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		nent or care planning resident's pain during					
	was observed chair in the ha window. The standing next to overheard indices was hurting and The Director of the request and obtain a pillow. On 5/5/11 at 2 Occupational Thysical Theratobserved assist ambulate in the resident became assisted the resident wheel chair moaned and greated. During time, the theratory of the resident was seated.	Therapist #1 and apist #1 were ting Resident F to e hall. When the ne tired, the therapists sident to be seated in ar. The resident rimaced as she was g interview at this pists indicated they a about her pain. :30 P.M., the					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		A. BUI	LDING	NSTRUCTION 00	COM	TE SURVEY IPLETED 5/2011	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODI		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	*	urrent facility policy agement," undated.					
		luded, "It is the					
		facility to respect and					
		sident's right to					
		nanagementIt is the					
		of all nursing staff to					
	_	iodically reassess the					
	_	in and relief from					
	painNursing	g shall also observed					
	for pain indica	tors: facial					
	expressionv	ocalizationsbody					
	movements	"					
	2. On 5/4/11 a	nt 12:30 P.M., PT					
	[Physical Ther	apist] #1 and OT					
	(Occupational	Therapist) #1 were					
	observed trans	ferring Resident E to					
	bed. The resid	ent was moaning out,					
	and a family m	nember at the bedside					
	indicated, "Hi						
	hurting." The						
		grimacing and					
	_	e being repositioned					
		6 then entered the					
		ve the resident's					
	_	This coccyx area. The					
	resident was o						
	moaning durin	g the dressing					

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE	LETED
		155621	A. BUI B. WIN	LDING		05/05/2	
			D. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
	change. A pres						
		ne coccyx. LPN # 6					
		lressing was changed					
		eeded. LPN # 6					
	indicated at th	at time that the					
	resident could	have Tylenol or					
	Lortab if need	ed. LPN # 6 indicated					
	the resident "	will usually ask for					
	it." LPN # 6 t	hen asked the					
	resident if his	back was hurting,					
	and indicated	to him, "It's probably					
	that arthritis."	Resident E indicated					
	he was hurting	g, but did not specify					
	where.						
		cord of Resident E					
		ewed on 5/5/11 at					
		agnoses included, but					
		ed to, cancer of					
	tongue, respira	•					
	pneumonia, ar	nd acute renal failure.					
	A D1	1 1 1 1 1 1 1 1 1 1					
	*	order, initially dated					
		the current April					
		ndicated, "Lortab					
		on]every 4 hours					
	·	pain." An additional					
	*	der, initially dated					
	2/28/11 and or	the current April					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	i .	E SURVEY PLETED /2011
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP CO TOCKER DR SVILLE, IN47720	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	· ·	ndicated, "APAP2 hours prn [as needed]				
	assessment, da indicated the r dependent on t bed mobility a not on a sched regimen or rec pain medication days, A Care Plan, d indicated a pro generalized, R experiencing p evidenced by] Related to: Ca included, "Mo indicators of p grimacing, mo Assessments a not to wait too medication as to take effect.	esident was totally two or more staff for and transfer, and was uled pain medication eived prn [as needed] ons, in the past 5 ated 4/20/11, oblem of "Pain, esident may be pain AEB [as Crying, moaning, neer." Interventions onitor for non-verbal ain such as: facial aningUpdate Pain is needed. Encourage long to ask for pain it will take it longer"				
	A Pain Assessi	ment, dated 4/27/11,				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULT A. BUILDIN B. WING		00	(X3) DATE S COMPL 05/05/2	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3	400 ST	DDRESS, CITY, STATE, ZIP CODE OCKER DR //LLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	symptoms of paches/pains Frowning/scool brow, Moanin condition, Car [osteoarthritis] Medication no pain or disc assessment peroceas. c/o's [congeneralized dispast month local A Medication Record [MAR indicated Resinguisted Lortab May. The MA resident receive Lortab once, or indicated the record indicated indicated indicated the record indicated in	Administration J. dated May 2011, dent E did not for the month of R indicated the red "APAP" on P.M. for "c/o back I April 2011, esident received on 4/9/11. The MAR esident received on APA, three times, on					

000442

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155621	A. BUILDING B. WING		05/05/2011
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 ST	IDDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the ir demonstrates that a resident having precessary treatment healing, prevent in sores from developed Based on observation interview, the factories was planned and prevention and careful and sores from and careful and prevention and careful and sores from and careful and prevention and careful and sores from and careful and prevention and careful and sores from and careful and sores from a sores f	ation, record review, and cility failed to ensure care implemented for are for pressure ulcers for eviewed related to a sample of 8.	F0314	Itt is tthe practice of tthis fiacilitt assure thatt all residents receive necessary care and services tto preventt and threatt pressure ulce The corrective acton taken fior those residents flound to be affect by the deficient practice include: Residents#E and #F have been reviewed tto assure thatt appropri	e tthe ers

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155621	B. WIN			05/05/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			VILLE, IN47720		
					VILLE, II 447720		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	· · · · · · · · · · · · · · · · · · ·	DATE	
	Findings include				measures are in place tto preventt		
					and/or ttreatt pressure ulcers Other residents that have the		
	1. During observ	vation on 5/2/11 at 4:45					
	a.m., Resident E	was observed lying on			potental to be afiected have been identfied by :		
	his back in bed o	on a specialty air mattress.			All residentts tthatt currenttly hav	_	
		he bedside preparing to			pressure ulcers have been reviewe		
		nt's Foley catheter bag.			tto assure tthatt proper ttreattmen		
	1 * *	at this time, CNA #7			and services are in place tto assist		
	I -				witth tthe healing ofl wounds		
		ident had a pressure			All residentts have been reviewed		
		ck, which had been			Those residentts identtfled as high		
	1	y, and pressure ulcers to			risk flor pressure ulcers have been		
	his heels.				reviewed tto assure tthatt tthere a	re	
					preventtve measures in place tto		
	The clinical reco	ord fro Resident E was			assistt witth tthe preventton ofl		
	reviewed on 5/2/	11 at 7:45 a.m. The			pressure ulcer developmentt		
		the resident was admitted			The measures or systemic change	5	
		2/12/11, discharged to			that have been put into place to		
	I -	_			ensure that the deficient practce		
	1 -	/10/11, and readmitted to			does not recur include:		
	the facility on 3/2	24/11.			Nursing sttafl has been inserviced relatted tto tthe preventton ander		
					ttreattmentt of pressure ulcer§he		
	The Pressure Ulo	eer Risk Assessment,			in-service included nott only tthe		
	dated 2/12/11, in	dicated the resident had a			acttual ttreattmentt and assessme	ntt ofl	
	high risk of press	sure ulcer, with a score of			pressure ulcers, butt also identtfly		
	9. The assessme	ent form indicated a score			tthose residentts tthatt eitther hav	ŭ	
	of 8 or above ren	presented high risk.			pressure ulcer or are att high risk o	ofl	
	Subsequent Pres	•			pressure ulcers tto assure tthatt		
	Assessments on				appropriatte intterventtons are in		
					place tto promotte healing an/br t	0	
	1	sk with scores of 8 on			preventt tthe developmentt ofl		
		Pressure Ulcer Risk			pressure ulcers. The nurses have a		
	l	3/5/11 indicated a score of			been in-serviced relatted tto flollo	wing	
	7.				tthe policy relatted tto providing		
					ttreattmentts in accordance witth		
	The Nursing Adı	mission Assessment,			accepttable guidelines ofl inflectto	n	
	1	dicated, "Bottom - red"			conttrol		
	·	*				 	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DB3N11 Facility ID:

000442

If continuation sheet Page 61 of 84

STATEMEN	NT OF DEFICIENCIES	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED		
		155621	B. WIN			05/05/2011			
		I	В. WIN		ADDRESS, CITY, STATE, ZIP CODE	l .			
NAME OF	PROVIDER OR SUPPLIEF	8		1	TOCKER DR				
PINF HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720				
						-	(7/5)		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE		
IAG	-	<u> </u>	+	IAG	The correctve acton taken to		DATE		
	in the section for				monitor perfiormance to assure				
	1 -	rs, dated 2/14/11,			compliance through quality				
	1	y Magic Butt Cream to			assurance is:				
	the buttocks ever	ry shift and as needed.			A Perflormance Improvementt Too	ol I			
					has been inittatted tthatt will be				
	During interview	y on 5/2/11 at 7:00 a.m.,			uttlized tto observe flor tthe provi	sion			
	LPN #6, Unit M	anager for Resident E's			ofl wound care assessmentt ofl				
	nursing unit, ind	icated the schedule for a			pressure ulcers, and tto assure tth	att			
	_	skin checks are on the			preventtve measures are in place	tto			
	1	ninistration Record. She			preventt tthe developmentt ofl				
		esident has a new skin			pressure ulcers. The ttool will				
					randomly review 5 residentts tto				
	_	for describing and			assure tthatt proper intterventton				
	tracking the wou	inds are started.			in place relatted tto tthe preventto				
					and/or ttreattmentt ofl pressure u The Directtor ofl Nursingor design				
	Nurse's notes, da	ated 3/8/11, at 10:00 a.m.,			will complette tthis auditt weekly.				
	indicated, "De	ep red colored area noted			montthly 3, tthen quartterly 3. Ar				
	to the (lt) [left] s	ide of coccyx. 3 cm X 4			issue identtfled will be immediatte				
	cm. Skin is inta	ct. Call placed to Dr.			correctted The Qualitty Assurance	,			
		ian]. Message left for			Committee will review tthe ttool a	tt			
		[resident] to be turned lt.			tthe scheduled meettng flollowing	tthe			
	to rt. [right] while	= =			completton ofl tthe ttool witth				
	to it. [light] will	ic in bed.			recommendattons as needed.				
	A Woolds No. 1	ambitus Danart datad			The date the systemic changes wi	11			
	1	ecubitus Report, dated			be completed:				
	· ·	, "Description: Dark			June 4, 2011				
		3 cm X 4 cm. Skin intact.							
	Bruise-like in ap	pearance."							
	A physician's ord	der, dated 3/8/11,							
	indicated, "Appl	y skin prep to bilateral							
	heels q [every] s	hift; float heels" and							
		on coccyx q shift."							
		J 1							
	A physician's or	der, dated 3/9/11,							
		ipodus boots while in							
	muicated, Mult	ipodus boots wille ili							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		A. BUIL	DING	NSTRUCTION 00 ———	(X3) DATE (COMPL 05/05/2	ETED	
		100021	B. WINC		DDRESS, CITY, STATE, ZIP CODE	00/00/2	
NAME OF I	PROVIDER OR SUPPLIER				FOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	bed."	ESC IDENTIF TING INFORMATION)		IAG			DATE
	ocu.						
	Documentation is	n Nurse's Notes and					
	wound sheets fai	led to indicate an					
	assessment of the	e resident's heels.					
		or 3/9/11 at 2:00 p.m.,					
	· ·	remains intact over areas					
		coccyxN/O's [new					
		eived] per Dr. [name of					
	physician] for wo	•					
	in bed. Turned r	s bil [bilateral] feet while					
		//c [wheel chair] for short					
	periods of time	•					
	periods of time	•					
	A Nurse's Note for	or 3/10/11 at 6:50 p.m.,					
		se was called to the room					
	by the resident's	spouse. The resident was					
	having difficulty	breathing, and bright red					
	blood was suction	ned from the mouth. The					
	resident was sent	to the hospital.					
	A hognital note f	rom the Wound Ostomy					
	_	e, dated 3/11/11 at 12:58					
		Here per consultwife at					
	_	orted to this RN that areas					
		y been there a couple of					
	l '	area has been a couple					
	l -	sment of bilateral heels					
	reveals two areas	s of pressure, closed					
	blood blister, is I	OTI (deep tissue injury).					
		tly closed, soft L [left]					
	heel wound meas	sures over all 3.5 X 4.5					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155621	A. BUI	LDING	00	05/05/2	
		133021	B. WIN			03/03/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
					VILLE, IIV-1120		(115)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
-	<u> </u>	t blood blister within this		_			
		es approximately 3 X 2.5					
		el wound measure overall					
		an intact blood blister					
	within this area t						
		5 X 0.2, this area will					
		no topical treatment if					
	1	mbolytic deterrent					
	_	t reapplied. Bilateral					
	1 3	ttered red, raised rash					
		ons that is yeast. Within					
		occyx there is an area of					
	1 -	just R of the gluteal cleft					
		t measure approximately					
		is dark, thick, adherent					
		nd skin is blanchable but					
		After yeast is resolved,					
	l *	ge in treatment orders to					
	1	f eschar at coccyx					
	A hospital note fi	rom the Wound Ostomy					
	1 ^	e, dated 3/24/11 at 10:28					
		WOCN here per nurse					
	request to reasses	ss wounds prior to patient					
		assessment reveals a					
	I -	ccyx that measure					
		X 4 cm. Within the					
	1 **	area of eschar that					
	measures approx	imately 1 X 1.5 cm. The					
		d bed is covered by thin					
	_	The edges are open, and					
	1 -	is intact. The skin within					
	1 ^	and extending out toward					
	1	ock and coccyx still has					

NAME OF PROVIDER OR SUPPLIER INCLUDENCE OR SUPPLIER INCLUDENCE OF SUPPLIER	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MU A. BUII		onstruction 00	(X3) DATE COMPL	ETED	
PINE HAVEN HEALTH AND REHABILITATION CENTER 240 D SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGILATORY OR ISC DISCRIPTIVING INFORMATION) REGILATORY OR ISC DISCRIPTIVING INFORMATION TAG REGILATORY OR ISCRIPTIVING INFORMATION TAG RECORDS THE EVANSUAL INFORMATION TAG REGILATORY OR IS ARE TO SERVICE TO SERV			155021	B. WIN		DDDEGG GITW GTATE ZIR CODE	03/03/2	011
PINE HAVEN HEALTH AND REHABILITATION CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCIES GACH DEFECIENCY MUST BE PRECIDED BY BUIL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG ROSS-REFERENCE OF TO THE APPROPRIANTE COMPLETION TAG COMPLETION DATE TAG COMPLETION COMPLETION COMPLETION COMPLETION COMPLETION COMPLETION TAG COMPLETION CACTOERCE MACROCOCO COMPLETION CACTOERCE MACROCOCO COMPLETION COMP	NAME OF F	PROVIDER OR SUPPLIER						
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Ted maculopapular rash with satellite lesions extending from the rash. This appears to be yeast. Although it appears to be improving, the rash has not resolved. For these reasons treatment cannot be changed. The right heel wound now measure approximately 3.2 X 5 cm. The area is an intact fluid filled blister. At the left heel is a wound that measure approximately 2.3 X 1.2 cm. This is an area of intact eschar. Discussed wound care with primary RN. When yeast resolves a Duoderm would be appropriate to provide autolytic debridement to the coccyx wound" The Pressure Ulcer Risk Assessment, dated 3/24/11, indicated the resident was high risk for pressure ulcers, with a score of 8 with 8 or above representing high risk. A physician's order, dated 3/24/11, with "Problem: At risk for pressure ulcer" had the goal: "Will not develop any pressure ulcers," Interventions indicated by check mark indicated, "Assess/record changes in								
red maculopapular rash with satellite lesions extending from the rash. This appears to be yeast. Although it appears to be improving, the rash has not resolved. For these reasons treatment cannot be changed. The right heel wound now measure approximately 3.2 X 5 cm. The area is an intact fluid filled blister. At the left heel is a wound that measure approximately 2.3 X 1.2 cm. This is an area of intact eschar. Discussed wound care with primary RN. When yeast resolves a Duoderm would be appropriate to provide autolytic debridement to the coccyx wound" The Pressure Ulcer Risk Assessment, dated 3/24/11, indicated the resident was high risk for pressure ulcers, with a score of 8 with 8 or above representing high risk. A physician's order, dated 3/24/11, indicated, "Apply Magic Butt to buttocks BID [two times daily]." The Care Plan, dated 3/25/11, with "Problem: At risk for pressure ulcer" had the goal: "Will not develop any pressure ulcers." Interventions indicated by check mark indicated, "Assess/record changes in								
red maculopapular rash with satellite lesions extending from the rash. This appears to be yeast. Although it appears to be improving, the rash has not resolved. For these reasons treatment cannot be changed. The right heel wound now measure approximately 3.2 X 5 cm. The area is an intact fluid filled blister. At the left heel is a wound that measure approximately 2.3 X 1.2 cm. This is an area of intact eschar. Discussed wound care with primary RN. When yeast resolves a Duoderm would be appropriate to provide autolytic debridement to the coccyx wound" The Pressure Ulcer Risk Assessment, dated 3/24/11, indicated the resident was high risk for pressure ulcers, with a score of 8 with 8 or above representing high risk. A physician's order, dated 3/24/11, indicated, "Apply Magic Butt to buttocks BID [two times daily]." The Care Plan, dated 3/25/11, with "Problem: At risk for pressure ulcer" had the goal: "Will not develop any pressure ulcers." Interventions indicated by check mark indicated, "Assess/record changes in		`				CROSS-REFERENCED TO THE APPROPRIA	ATE	
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The Care Plan, dated 3/25/11, with "Problem: At risk for pressure ulcer" had the goal: "Will not develop any pressure ulcers." Interventions indicated by check mark indicated, "Assess/record changes in		indicated, "Apply	y Magic Butt to buttocks					
"Problem: At risk for pressure ulcer" had the goal: "Will not develop any pressure ulcers." Interventions indicated by check mark indicated, "Assess/record changes in		BID [two times of	daily]."					
"Problem: At risk for pressure ulcer" had the goal: "Will not develop any pressure ulcers." Interventions indicated by check mark indicated, "Assess/record changes in		The Core Plan detect 2/25/11 with						
the goal: "Will not develop any pressure ulcers." Interventions indicated by check mark indicated, "Assess/record changes in		·	·					
ulcers." Interventions indicated by check mark indicated, "Assess/record changes in			_					
mark indicated, "Assess/record changes in		_						
i okin otatuo. Noduli delinieni enangeo iii i i i i i i i i i i i i i i i i i			_					
skin status to MD, Monitor lab results as								
ordered and report abnormal results to								

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/05/20	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u>"</u>			DDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	hours, Specialty cushion, Provide each incontinent	and reposition every two bed/mattress, Chair incontinence care after episode, Avoid skin to nimize pressure over es."					
	dated 3/31/11, in	cer Risk Assessment, dicated the resident was ssure ulcers with a total					
	Documentation failed to indicate the care plan was updated related to the increased risk.						
	dated 4/7 and 4/2 resident continue	cer Risk Assessments, 14/11, indicated the ed to be a high risk for with a total score of 13 on					
	Documentation failed to indicate the care plan was updated related to the increased risk.						
	dated 3/24/11, in coccyx: "Date: A Width: 8 X 5 Location & extensinus tract: N/A Exudate: N/A; I	cer Documentation form,, adicated a wound to the 3/24/11; Stage: 2; Length [cm]; Depth: 0.5 [cm]; ant of any tunneling or [not applicable]; Pain: 0; Color: Red & Dee: Granulation; Describe					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2	2) MULTIPLE CO			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Α.	BUILDING	00		COMPL	
		155621	В.	WING			05/05/2	011
NAME OF I	PROVIDER OR SUPPLIER	•	<u> </u>	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
TWINE OF I	NO VIDER OR SUITER	•			FOCKER DR			
PINE HA	VEN HEALTH AND	REHABILITATION CENTE	R	EVANS'	VILLE, IN47720)		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FUI		PREFIX	CROSS-REFERENC	VE ACTION SHOULD BE CED TO THE APPROPRIATI	≣	COMPLETION
TAG		LSC IDENTIFYING INFORMATIO	ON)	TAG	DEI	FICIENCY)		DATE
	_	unding Tissue: Red;						
	When physician	notified/saw: 3/24/11."						
	The Claim I Ilean F	Da						
		Documentation form,						
		d 4/1/11 indicated a	,					
		rum, "Stage: 2; Length X	<u> </u>					
	Width: 6 X 4.1;							
	•	te, or pain]; Color: Pink	· I					
		nulation; Describe Edge	s					
	and Surrounding	Tissue: Red.						
	The nevt accessm	nent of the wound was						
		d was described as a						
		rum. Documentation						
	_	Eschar; Length X						
		6; Depth: 0.2; Location						
	_	unneling or sinus tract:						
	· ·	Purulent; Pain: 3; Color	;					
	_	Γissue Type: Eschar						
		e Edges & Surrounding						
		und margin; When						
		d/saw: Seen by [name o	f					
	wound consultan	t] this date."						
	The next accessm	nent of the wound was						
		The space for the wound						
		"Length X Width: 3.2 X	,					
	_	Location & extent of	`					
		sinus tract: None;						
		nt; Pain: 3; Color:						
	•	Describe Edges &						
	_	sue: Distinct attached;						
	When physician							
	Measurement per	r wound specialist."						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event l	ID: DB3N	V11 Facility I	D: 000442	If continuation sh	eet Pa	ge 67 of 84

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CO A. BUILDING B. WING	00	СОМ 05/05	E SURVEY PLETED /2011
	D REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP TOCKER DR VILLE, IN47720	CODE	
PREFIX (EACH DEFICII	STATEMENT OF DEFICIENCIES ENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
related to the cay wound upon re 3/24/11, LPN # Resident E's hat when the wound Resident E, the red and dried, a had been order indicated the way providing care eschar began to developed. Nurse's Notes from indicated, "Wo [name] @ facilino. [new order [telephone order Itelephone Itelephone Itelephone order Itelephone order Itelephone Itelephon	for 4/18/11 at 6:45 p.m. me of provider] updated on tress. Awaiting delivery of the as ordered." for 4/18/11 at 8:00 p.m. mattress delivered &				

Facility ID:

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE : COMPL	
		155621	A. BUI B. WIN	LDING		05/05/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	TOCKER DR		
		REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG				IAG	DEFECT.		DATE
	X width X depth	· · · · · · · · · · · · · · · · · · ·					
		on sacrum has yellow					
	1	for with] 60% eschar and					
		ins the is unstageable at					
	this time." The p						
		turrent treatment to the					
		d obtain an alternating					
	pressure air matt	ress.					
	A physician's ord	ler, dated 4/18/11,					
		e sacral wound [symbol					
	l '	cleanser, apply Santyl					
	1 -	, 11 3					
	1 2	cover [symbol for with]					
		gauze, secure [symbol					
	_	land, [symbol for					
		ery day] and PRN [as					
	needed] soiling."						
	The wound cons	ultant's note for 4/25/11					
	indicated the resi	ident's sacral wound was					
	debrided with a s	sharp scalpel to 3.0 cm X					
		granulating base.					
	The wound const	ultant's note for 5/2/11					
	indicated the sac	ral wound was 3.5 X 4.3					
	X 1.2 at a Stage	III. The assessment					
	indicated, "Decu	bitus ulcer on sacrum has					
	100% yellow slo	ugh [symbol for with]					
	tunneling, w/o [v						
		40 P.M. PEEPI					
		40 P.M., PT [Physical					
	^ *	d OT [Occupational					
	_ ^ -	ere observed transferring					
	Resident E to be	d. The resident 's coccyx					

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	A. BUILDING	E CONSTRUCTION 00	COM	TE SURVEY IPLETED 5/2011
	PROVIDER OR SUPPLIER		3400	ET ADDRESS, CITY, STATE, STOCKER DR NSVILLE, IN47720		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TO THE APPROPRIATE	(X5) COMPLETION DATE
	the dressing, whi amount of tannis indicated the worth the wounds, and staged as a Stage observed to have and to have depth. B. The Skin Ulc dated 3/24/11, 3/ pressure ulcer to resident had a 10 depth, tunneling, was described as brown," and "ski Tissue Type was "closed blister," Edges and Surror described as "blist The Skin Ulcer I dated 4/8/11 indic closed blister with and Surrounding blister." The Skin Ulcer I dated 4/15/11, when the skin Ulcer I	er Documentation form, 31/11, and 4/1/11, for a the left heel indicated the X 8 cm Stage II with no or exudate. The Color "brown blister," "skin is n brown & intact." The described as: "blister," and "closed blister." The unding Skin were ster" each week. Documentation form, cated a 10 X 8 brown th description of Edges Tissue as "Fluid filled Documentation form, as blank.				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155621	- 1	LDING	00	05/05/2	
		100021	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2	011
NAME OF F	PROVIDER OR SUPPLIER				TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		ler, dated 3/28/11,	+	IAU			DATE
	1 ^ *	-podus boot to lt [left]					
	· ·	" with "Indication - Dx					
	[diagnosis] bliste						
		i to Et neel.					
	The wound const	ultant's note, dated					
	· ·	d the resident's left heel					
	1 ^	was a deep tissue injury					
	$2.8 \times 3.4 \times < 0.1$	1, which was 100% black.					
	C. The Skin Ulc	er Documentation form,					
		31/11, 4/1/11, and 4/8/11,					
	· ·	eer to the right heel					
	1 1	dent had a 4 X 2 cm					
	Stage II with no	depth, tunneling, or					
	exudate. The Co	lor was described as					
	"Red/brown." Tl	he Tissue Type was					
	described as: "Cl	osed." The Edges and					
	Surrounding Skir	n were described as					
	"Red" each week						
	The Skin Ulcer I	Documentation form,					
	dated 4/15/11, wa						
	The wound const	ultant's note, dated					
		d the resident's right heel					
	_	was an unstageable deep					
	tissue injury 2.5	X 1.2 X < 0.1.					
	The plan for both	of the heel ulcers was					
	_	odus boots and skin prep					
	to the heels.						
	On 5/4/11 at 12:4	40 P.M., PT # 1 and OT #					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL	
		155621	A. BUI B. WIN	LDING IG		05/05/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE	!	
		REHABILITATION CENTER		1	ΓOCKER DR VILLE, IN47720		
				<u> </u>	VILLE, IN47720		are.
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	1 were observed	transferring Resident E					
	to bed. A family	member indicated, "Oh,					
		his sock." A bloody spot					
		the resident's sock. PT #					
		t time that, "We know.					
	1	o tell the nurse, that					
	1	ne off of his left heel." A					
		was requested at that					
		lifted the resident's left					
		n area was observed,					
		e size of a quarter, with					
	right heel was ob	of bleeding noted. The					
	1 ~						
	1	kin intact. PT #1 then the multi-podus boots to					
	1 -	6 then entered the room					
	ı ~	Therapy saved the eschar					
	· ·	played the scab-like area					
	in a glove.	prayed the seab-like area					
	in a giove.						
	On 5/5/11 at 12:1	10 P.M., the clinical					
	record of Resider	nt E was again reviewed.					
	Documentation v	was lacking regarding the					
	left heel eschar c	oming off of the					
	resident's left hee	el. A physician's order for					
	a different treatm	nent for the heel was					
	lacking. LPN # 6	was interviewed at that					
	1	e treatment for Resident					
		indicated, "He gets the					
	1 *	ts." LPN # 6 indicated					
		rved the resident's left					
		char had come off, and					
		the physician of that fact.					
	LPN #6 indicated	d she would contact the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE (A. BUILDING	OONSTRUCTION OO	li i	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		3400	TADDRESS, CITY, STATE, ZIP STOCKER DR SVILLE, IN47720	_	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
		liately, and obtain				
	she had contacted ordered Bacitrac twice daily, then Kling dressing. I also received an heel with a Kling indicated the phy how the scab had I didn't know."	O P.M., LPN # 6 indicated d the physician, and he in [antibiotic cream] to cover with Telfa and a LPN # 6 indicated she order to wrap the right g dressing. LPN # 6 vsician "wanted to know I come off, and I told him				
	the Director of N	eemed to be missing from				
	the Director of N understood the coulcers. She indice her job at the fact was uncertain if not actually been inaccurately because	fursing indicated she concern related to pressure cated she had just started ility on 5/2/11, and she the resident's wound had assessed, or assessed cause the nurse needed wounds and wound care.				
	reviewed on 5/2/ record indicated	ecord for Resident F was 11 at 6:25 a.m. The the resident was admitted wing placement of a				

000442

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155621		(X2) MU A. BUII		NSTRUCTION 00	COMPL	ETED	
		155621	B. WIN			05/05/2	U11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	The Pressure Ulc dated 4/16/11 inchigh risk for pressure ulcers of the April 2011 indicating the resident had was signed with a indicating the resident had the prominence). The Medication A was signed with a indicating the resident had the prominence of the April 2011 indicating the residuction of the Ulcer of April 2011 indicating the residuction of the Ulcer, 7 X 6 cm and color. On 4/23/1 Stage 1 ulcer, within the column for documentation with the ulcer on 4/30. A physician's ord "Apply Magic Bugroin/buttock q [and the Ulcer of Indicating the ulcer of Indicating the ulcer of Indicating the residual to the Ulcer of Indicating the Indicating	rer Risk Assessment, licated the resident had a sure ulcers. Ininimum Data Set d 4/23/11, indicated the e Stage 1 pressure ulcer non-blanchable redness a usually over a bony Administration Record a nurse's initials sident's skin was assessed d/16, 4/23, and 4/30/11. Documentation Sheet for a ted the following for nother buttocks: On lent had one Stage 1 with no depth and red in 1, the resident had one th "excoriation" written the length X width. No as indicated to describe 1/11.					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	r í	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A 3400 S	ADDRESS, CITY, STATE, ZIP TOCKER DR VILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	at 11:00 a.m. indresting in bed quand reposition] enoted to have minemorrhoidal ble excoriated. She scratching/excorrectum but [symbol for symbol for given [symbol for given [symbol for given [symbol for with the symbol for with the symbol for with the buring observation and steep in the symbol for with the perineal and cleansed, the result of the symbol for with	Charting notes for 4/29/11 icated, "Res. [resident] ietly. Upon T & R [turn t [and] incont care, res. In [minimum] -moderate reding et buttocks very has superficial iation along both side of bol for no] drainage et l. MD notified of ymbol for no] pain ont [incontinent] care is or after] loose BMs ats] et she gets her rectum tion H [hemorrhoid ied per order along and Magic Butt Cream." Jon on 5/2/11 at 10:30 dd CNA #6 were observed inent care for Resident F. and buttocks areas were ident cried out, "Oh, that ig." CNA #4 indicated the is area had been more red Friday (4/29/11), and she mall bright red areas ear the anal area, and an low open area was coccyx. The resident gd down here - it hurts" and the perianal area. Indicated the resident ed of pain when she was				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155621	A. BUI	LDING	00	05/05/2	
		155021	B. WIN			03/03/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR		
PINF HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE
	wet and when inc	continent care was					
	provided, and they indicated they often						
	had the resident l	nold the hands of one					
	CNA so the other	r could provide care as					
		d be combative during					
	incontinent care.	Immediately after the					
	· ·	nurse, LPN #5 was asked					
	1	n area to the coccyx as					
	soon as possible.						
	During interview on 5/2/11 at 12:40 p.m.,						
	LPN #5 indicated	· ·					
		dent's wound, when the					
	_	ssisting the resident back					
		cated the wound was a					
		ulcer right on the					
		entation of the wound					
	_	requested at this time, and I a form entitled, "Skin					
	1 -	ation," dated 5/2/11,					
		Resident F had a Stage 2					
		easuring 0.8 X 0.9 cm					
	with less than 0.1	_					
		ndicated the nurse was					
		the resident's pain.					
		- r ·· ·					
	Nurse's Notes for	r 5/2/11 at 11:00 a.m.					
	indicated, "She	cont. [continues] to have					
		ttocks from scratching et					
	[and] is also note	ed to have St. [Stage 2]					
	area to coccyx 0.	8 X 0.9 depth is < [less					
	than] 0.1 cm et C	OA [open area] is only					
	inclusive of very	top layer of skin. Area					
	is red [symbol fo	r without] exudate noted.					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			SURVEY ETED
		155621	B. WING	ing		05/05/2	011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	;	3400 ST	DDRESS, CITY, STATE, ZIP CODE OCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	MD [physician] 1	notified for treatment"					
	cover [symbol fo [dressing], [symbol PRN [as needed]	y Xenaderm to coccyx, r with] foam drsg ool for change] daily & ."					
	preprinted form was at risk for pr marks next to int	ated 4/18/11, was a indicating the resident essure ulcers with check erventions for e skin, reporting changes					
	to the physician, monitoring of me feedings and mon	administering and edications, providing nitoring dietary needs,					
	monitoring effect	sitioning, providing and tiveness of pressure ction devices for bed and incontinent care.					
	avoiding skin to minimizing press prominence.						
	preprinted form i had a Stage 2 pre	ated 5/2/11, was a indicating the resident essure ulcer. The interventions were					
	added to the plan	: "Monitor					
	abnormal results						
		nitor effectiveness of ment(s) as ordered," and					
		d for and provide					

NAME OF PROVIDER OR SUPPLER PINE HAVEN HEALTH AND REHABILITATION CENTER INCO. 10 SERRET ADDRESS, CITY, STATE, ZIP CODE 3400 XSVILLE, INAT720 (XS) SERRET ADDRESS, CITY, STATE, ZIP CODE 400 XSVILLE, INAT720 (XS) REGULATORY OR 1.5C IBINTHIVING INFORMATION) CONSultation as needed." This federal tag is related to Complaint #IN00089626. 3.1-40(a)(2)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG consultation as needed." This federal tag is related to Complaint #IN00089626.	AND PLAN O	OF CORRECTION			00	
PINE HAVEN HEALTH AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG Consultation as needed." This federal tag is related to Complaint #IN00089626.			.00021		ADDRESS CITY STATE ZIPCODE	30,00,20
PINE HAVEN HEALTH AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) This federal tag is related to Complaint #IN00089626. EVANSVILLE, IN47720 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE (X5) COMPLETION DATE This federal tag is related to Complaint #IN00089626.	NAME OF PR	ROVIDER OR SUPPLIER				
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Consultation as needed." This federal tag is related to Complaint #IN00089626.				EVANS		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE CONSUltation as needed." This federal tag is related to Complaint #IN00089626.					PROVIDER'S PLAN OF CORRECTION	
consultation as needed." This federal tag is related to Complaint #IN00089626.					CROSS-REFERENCED TO THE APPROPRI	AIE
#IN00089626.						
		Consultation as no This federal tag i #IN00089626.	eeded."	TAG	DEFICIENCY)	DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/05/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET 3400 S	ADDRESS, CITY, STATE, ZIP CODE STOCKER DR SVILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	The facility must elegant processional practions of discovered to the prevent transmission of discovered transmission of the prevent determines that a prevent the spread must isolate the recommunicable discovered discovered transmission of direct disease. (3) The facility must hands after each of which hand washing professional practice.	stablish and maintain an Program designed to provide and comfortable environment and the development and sease and infection. Tol Program stablish an Infection Control with the development and sease and infection. Tol Program stablish an Infection Control with the controls, and prevents cility; Torocedures, such as the applied to an individual cord of incidents and the related to infections. The add of Infection control Program resident needs isolation to the difference of the facility will be a contact with residents or contact with residents or contact will transmit the contact resident contact for the gis indicated by accepted	IAU		DATE
	transport linens so infection. Based on obse and record rev failed to ensur	rvation, interview, iew, the facility e its infection control cocedures were	F0441	Itt is tthe practice of tthis fiacilitt assure tthatt all residents receive necessary care and services tto preventt and ttreatt pressure ulce The corrective action taken fior	tthe

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155621	B. WIN			05/05/20	011
					ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF	PROVIDER OR SUPPLIEF	C		3400 S	TOCKER DR		
	VEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	•	LSC IDENTIFYING INFORMATION)	+	IAU	those residents fiound to be afiec	tod	DATE
		e deficient practice			by the deficient practce include :		
		2 residents reviewed			Residentt#E receives catthetter can	re in	
	related to Fole	ey catheter			accordance witth tthe accepttable		
	management i	n a sample of 8			parametters ofl inflectton conttrol		
	(Resident E) a	and 1 of 2 residents			Residentt#H receives dressing		
		ng dressing change in			changes in accordance witth tthe accepttable parametters ofl inflect	ton	
					conttrol		
	a sample of 8	(Resident II).			Other residents that have the		
					potental to be afiected have been	,	
	Findings include:				identfied by :		
					All residentts tthatt currenttly hav		
	1. During obs	servation on 5/4/11 at			floley catthetters have been review tto assure tthatt tthe catthetter is	ved	
	1	#7 was observed			provided appropriattely in		
	1 * 1	and care for Resident			accordance witth inflectton conttr	ol	
	1				guidelines.		
		placed a package of	All residentts tthatt have identtfled				
	Kerlix and a p	ackage of Coban on			ttreattmentts have been reviewed		
	the floor next	the resident's feet,			assure tthatt ttreattmentts are pro in a manner tthatt is witthin accep		
	and donned cl	ean gloves. The			parametters of inflection contirol		
	resident provi	ded a folded blanket			The measures or systemic change	s	
	_	o sit on in front of the			that have been put into place to		
					ensure that the deficient practce		
		el chair. RN#7			does not recur include:	tod	
		on the blanket and			Nurses have been in-serviced relate tto tthe provision of ttreattmentts		
	assisted the re	sident to raise the			appropriattely in accordance witth		
	right pant leg.	A wound was			flacilitty policy and accepttable		
		ne back of the right			parametters ofl inflectton conttro	he	
	calf. No dressing was on the				in-service included tthe procedure		
	_				esttablish a clean surflace and pro	per	
	wound. The nurse opened a				hand washing and glove changes. All nursing sttafl and ttherapy sttaf	,	
	package containing a Prisma				have been in-serviced relatted tto	.	
	dressing, and	placed the Prisma on			appropriatte care tto be provided	flor	
	the wound and	d covered it with a			tthose residentts tthatt have floley	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155621	A. BUI	LDING	00	COMPLETED 05/05/2011
		100021	B. WIN			05/05/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
PINF HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720	
(X4) ID		TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	gauze pad. Th	e nurse picked up the	ĺ		catthetters The in-service includes	
	package of Ke	rlix from the floor,			assuring tthatt tthe catthetter bag remains below tthe level of tthe	
	opened it, and	wrapped the leg with			bladder and tthatt itt should neve	r be
	_	The nurse then picked			allowed tto ttouch tthe floor	
	_	e of Coban, opened it,			The correctve acton taken to	
	and wrapped the	, .			monitor perfiormance to assure compliance through quality	
	* *	hout changing gloves			assurance is:	
	_	0 00			A Perflormance Improvementt Too	ol
	and washing hands, the nurse removed the sock on the resident's				has been inittatted tthatt will be	
					uttlized tto monittor tthe provision wound care and tto assure tthatt	n ofl
	left foot, and opened a package of skin prep, which she applied to a				ttreattmentts are perflormed	
					appropriattely In additton, a	
	dark red raised	l area on the			separatte Perflormance Improven	nentt
	resident's seco	nd toe of the right			Tool will be uttlized tto observe	lantta
	foot.				inflectton conttrol flor tthose resident that the affoley catthetter that the terms of the transfer in the tra	ientis
					ttools will randomly review5	
	The clinical re	cord for Resident H			residentts(ifl applicable) tto assure	
		on 5/2/11 at 2:00			tthatt services provided are in accordance witth inflection conttr	
		on 3/2/11 at 2. 00			guidelines. The Directtor of Nurs	··
	p.m.				or designee, will complette tthis a	-
	Dlandalan	1 C M 2011			weekly x3, montthly x3, tthen	
	3	ders for May 2011			quartterly 3. Any issue identtfled	
	ŕ	vere not limited to,			will be immediattely correcttedThe Qualitty Assurance Committee wil	
		anterior rt [right] leg			review tthe ttool att tthe schedule	
	& posterior rt	leg [symbol for with]			meettng flollowing tthe completto	
	Prisma matrix	cut to wound size.			tthe ttool witth recommendattons needed.	as
	Cover [symbol	l for with] dry 4 X 4			The date the systemic changes w	;;;
	dsg [dressing]	gauze, wrap [symbol			be completed:	
		x & secure [symbol			June 4, 2011	
	for with Coba	= *				
	change] M-W-	, L J				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE S COMPL		
		155621	B. WIN			05/05/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			TOCKER DR VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	VILLE, IIVI7720		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Wednesday - F						
	physician's order, dated 5/2/11,						
	indicated the d	lressing should be					
	changed every	other day.					
	The facility's policy entitled						
		olication," dated 8/08,					
	_	by the Director of					
	Nurses (DON) on 5/5/11 at 3:15						
	p.m. The policy included, but was						
	not limited to,	"Purpose: To					
	prevent infecti	on in an open area					
	and prevent co	ontaminated drainage					
	from touching	clothes or linen.					
	Procedure4.	Make a barrier at the					
	bedside with a	towel or					
	washcloth1	1. Apply the clean					
	dressing. 12. R	Remove your					
	gloves14. W	Vash your hands with					
	soap and water						
		2:30 P.M., PT (Physical					
	• ′	d OT (Occupational					
	• ′	ere observed transferring d. The Foley catheter bag					
		be lying on the floor					
		er, and during the					
	positioning of the	_					
	0 5/5/11 110	10 D.M. 1:					
	On 5/5/11 at 12:1	requested on Resident E.					
	assessment was I	equested on resident iz.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621		(X2) MULT A. BUILDI B. WING		OO	(X3) DATE S COMPL 05/05/2	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	S 3	3400 ST	DDRESS, CITY, STATE, ZIP CODE OCKER DR IILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
	REGULATORY OR When entering the catheter bag was floor. LPN # 6 are resident's heels, Foley catheter bath and the catheter bath and	ne room, the Foley observed lying on the sessesed both of the but she did not move the ng off of the floor. and of Resident E was on 5/5/11 at 12:30 P.M. A r, initial date unknown but orders, indicated, " eter]d/t [due to] ed 4/28/11, indicated a mary Catheter, At risk for olications due to catheter erventions included, but to, "Provide catheter			CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	
	the Director of N	O P.M., during interview, Tursing indicated the ald not have been on the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 5/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIF TOCKER DR SVILLE, IN47720	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE
	floor at any time 3.1-18(b)(2) 3.1-18(l)					